DOCUMENT RESUME

ED 078 244 AC 014 422

TITLE	Re-Entry into Community Opportunities, Vocations, Education and Recreation (RECOVER). Final Report.
INSTITUTION	Comprehensive Mental Health Center of Tacoma - Pierce County, Wash.
SPONS AGENCY	Social and Rehabilitation Service (DHEW), Washington, D.C. Div. of Research and Demonstration Grants.
PUB DATE	Nov 72
NOTE	121p.
EDRS PRICE	MF-$0.65 HC-$6.58
DESCRIPTORS	*Adjustment Problems; *Adult Counseling; Crisis Therapy; Emotional Adjustment; Group Therapy; *Mental Health Programs; Milieu Therapy; Program Descriptions; Rehabilitation Counseling; *Rehabilitation Programs; Social Adjustment; Vocational Counseling

ABSTRACT

RECOVER is a developmental aftercare team of professionals and paraprofessionals organized to serve the total person with versatility. Coordinated expertise of the team was focused on providing action-type opportunities for starting developmental processes in clients. Methods included counseling, groups, crisis intervention, cluster apartment living, social milieu, education, job-samples, recreation and meeting clients' needs through knowledge of community resources with active involvement and field work. The aim was to start positive snowballs. Then the aim was to keep them rolling. Comparisons between different groups and pre- and post-program functioning consistently showed improvement for graduates in terms of rehospitalization rates, employment, social functioning and self-concept. The majority also were judged by staff to have attained objectives and made gains. Most clients require years to consolidate gains and develop further; thus, a program must endure itself if growth is to continue. By becoming part of a mental health center and taking advantage of relevant titles of the Social Security Act and DVR case costs, the program can survive and continue starting new clients and backing-up Graduates. Personal relations, comprehensive aid, persistence and opportunities for learning by doing are seen as essential aspects of effective psychiatric rehabilitation. (Author)

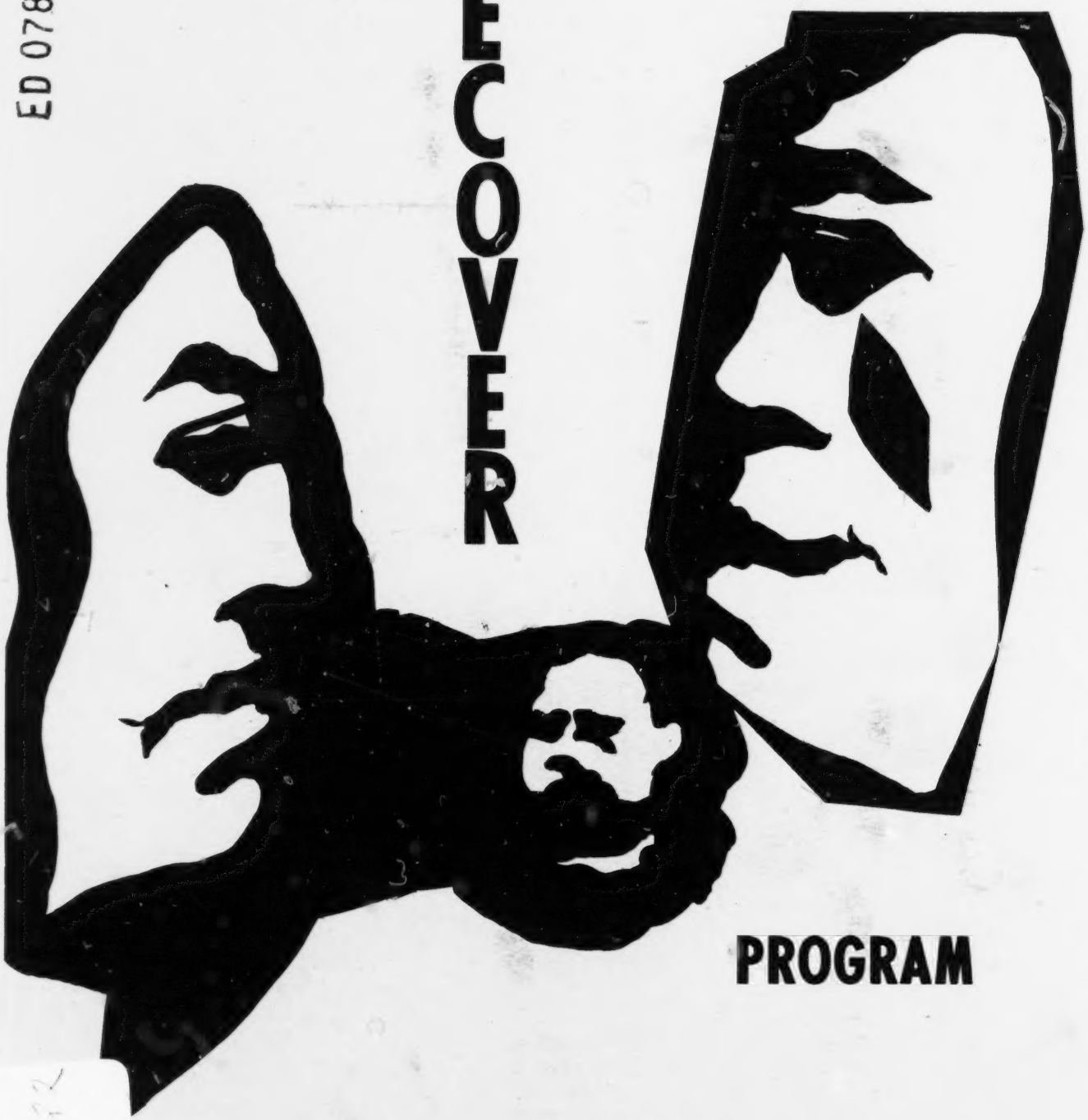
FILMED FROM BEST AVAILABLE COPY

U.S. DEPARTMENT OF HEALTH
EDUCATION & WELFARE
NATIONAL INSTITUTE OF
EDUCATION
THIS DOCUMENT HAS BEEN REPRODUCED EXACTLY AS RECEIVED FROM THE PERSON OR ORGANIZATION ORIGINATING IT. POINTS OF VIEW OR OPINIONS STATED DO NOT NECESSARILY REPRESENT OFFICIAL NATIONAL INSTITUTE OF EDUCATION POSITION OR POLICY.

AC

ED 078244

RECOVER



PROGRAM

AC 1-72

FILMED FROM BEST AVAILABLE COPY

Significant Findings for Rehabilitation (and Social Service) Workers

Psychiatrically disabled people differ widely. Some require assistance and guidance in most aspects of personal and community living; others require it only in a few key areas. They are all unique, as are the configurations of their requirements. If long-range effects are to be achieved, a program must be able to avert failure experiences and offer diverse opportunities for development. Because clients' needs are heterogeneous, a broad gamut of services is necessary.

To varying degrees, clientele of community-based programs need combinations of services of which the following are illustrative: human relationships with counselors, other staff, peers and people from the community; crisis intervention; planned and informal social and recreational activities; a multitude of concrete services from social living arrangements to transportation, advocacy and legal aid; medical and dental care with careful supervision of medication; broad opportunities to learn and develop skills from daily living requirements to general and vocational education; opportunities for action-type experiences and learning-by-doing such as job-samples, client businesses and self-help organizations; and the backing of periodic follow-up contacts and the provision of post-program services as necessary.

A major problem is meeting such diverse needs within budgetary limitations. RECOVER approached this problem by means of a coordinated team of professionals and paraprofessional Expediters. Team members conjointly both provided and from community resources obtained combinations of services for dealing with various configurations of client needs. Expediters, in particular, served as implementers and trouble-shooters for obtaining, maintaining and utilizing services and resources available in the community.

Paying attention to the "little things" as well as the conventional big areas such as medication, employment, housing and socialization all in a broad context of human relationships enables clients to learn that they can win and that others can care, all of which helps combat the ubiquitous feeling of inadequacy and anomie. As experiences extend, the big areas add that much more to stability and effectiveness.

The mental health centers movement places priorities on serving a wide range of people. This requires more staff and deepens budgetary problems. An adaptive sequel for centers, therefore, has been more group and short-term therapy. For people most deeply afflicted, these are not adequate substitutes for the necessary long-term care. To effectively meet aftercare and rehabilitation needs of disabled ex-mental patients, special team approaches are particularly pertinent if they are able to endure over time. Thus, it is essential that aftercare programs pay their way. With the existing National Rehabilitation and Social Security legislation this is possible. Populations served are largely both disabled and destitute, and programs serving these people are legally entitled to case costs and/or fees for service once necessary contractual arrangements are established.

Continuity of services means effective linkage of clients with sequences of multiple services, preferably with one person who has access to specialists' expertise guiding and supporting each client through a continuum of care. Equally important, continuity means indefinite availability of programs so that a slip does not start a spiral of regression. Many R&D projects have amply demonstrated that rehabilitation of the psychiatrically disabled is not permanent. Such complexly disabled people are neither "cured" nor "rehabilitated." But they can begin a developmental process that can continue for life, if the help is there to avert every slip meaning two steps backward following one forward.

RE-ENTRY INTO COMMUNITY OPPORTUNITIES, VOCATIONS, EDUCATION AND RECREATION (RECOVER)

FINAL REPORT

H. J. Wahler, Ph.D.
Project Director

Paul Gergen, M.S.
Project Coordinator

Comprehensive Mental Health Center
of Tacoma-Pierce County
1419 South Yakima Avenue
Tacoma, Washington 98405

November, 1972

This investigation was supported, in part, by Research Grant No. RD 12-P-55329 (formerly No. RD-3020-GA) from the Division of Research and Demonstration Grants, Social and Rehabilitation Service, Department of Health, Education and Welfare, Washington, D. C. 20201.

TABLE OF CONTENTS

		Page
ABSTRACT		iii
RESEARCH BRIEF		iv
ACKNOWLEDGMENTS		vii
1.	REVIEW OF OTHER PROGRAMS	1
	Clientele	2
	Services	3
	Program Evaluation	7
2.	OVERVIEW OF THE RECOVER PROGRAM	11
	Methods	11
	Services	13
	The Service Delivery Team	19
3.	PROGRAM EVALUATION: METHODS AND MEASURES	28
	Subjects	28
	Measures	31
4.	MAJOR FINDINGS	37
	Background Comparisons	37
	Self-Description and Ability Test Comparisons	42
	Counselor Assessments of Assets, Liabilities & Objectives	43
	Outcome Comparisons	52
	Pre-Post In-Hospital-Time	53
	Pre-Post Employment	55
	Pre-Post Adequacy	58
	Effects of Follow-Up Attrition	60
	Pre-Post Self-Description	61
	Additional Outcome Measures and Correlations	63
	Summary of Outcome Findings	68
	Cost and Potential Savings	70
	Clients' Evaluation of Program Benefits	71
5.	DISCUSSION AND CONCLUSION	73
REFERENCES		77
APPENDICES		82

ABSTRACT

RECOVER is a developmental aftercare team of professionals and paraprofessionals organized to serve the total person with versatility. Coordinated expertise of the team was focused on providing action-type opportunities for starting developmental processes in clients. Methods included counseling, groups, crisis intervention, cluster apartment living, social milieu, education, job-samples, recreation and meeting clients' needs through knowledge of community resources with active involvement and field work. The aim was to start positive snowballs. Then the aim was to keep them rolling.

Comparisons between different groups and pre- and post-program functioning consistently showed improvement for Graduates in terms of rehospitalization rates, employment, social functioning and self-concept. The majority also were judged by staff to have attained objectives and made gains. Most clients require years to consolidate gains and develop further; thus, a program must endure itself if growth is to continue. By becoming part of a mental health center and taking advantage of relevant titles of the Social Security Act and DVR case costs, the program can survive and continue starting new clients and backing-up Graduates. Personal relations, comprehensive aid, persistence and opportunities for learning by doing are seen as essential aspects of effective psychiatric rehabilitation.

Research Brief

To correct the gross deficiencies in care for the mentally ill found by the Joint Commission, hospitals were urged to release patients more quickly and communities were to be aided in developing facilities for adequate aftercare through the Comprehensive Mental Health Centers Act. Since 1955, the increase in community-based facilities is about three-fold and the median length of stay for the nation dropped from 211 days to 57 days--nearly a four-fold decrease.

Despite these gains, over three times more patients are being re-admitted to hospitals. The national efforts to confront mental illness face-on seem to miss the very people most deeply afflicted. With tranquilizing drugs, it is often possible to alleviate symptoms quickly which is then the basis for early release. But after symptoms of an acute episode have subsided, the assistance most grievously needed is of a social, educative, supportive and advocative nature aimed at developing human relations, strengths, and abilities.

Unfortunately, essentially no public agencies or special services have been created expressly for such purposes. A major weakness found by many researchers has been the failure to provide for community support and follow-up. Not only do ex-patients have the residuals of their own problems to deal with, but a majority also live in poverty and tend to be rejected by citizens, relatives and employers as well.

Most hospitals depend upon referrals to private physicians, public assistance, community clinics or mental health centers for aftercare. However, like hospitals themselves, such resources typically lack the time and personnel with relevant interests and background for undertaking the long-term job of rehabilitating seriously disabled ex-patients.

Implications for Action

Traditional treatment and rehabilitation methods are generally ineffective for implementing a transition from the role of chronic psychiatric disability to one of effective self-sufficiency.

At our present level of knowledge, it appears that restoration of psychosocially disabled people is not dependent upon developing new techniques but instead upon developing approaches which permit flexible application of known techniques in combinations and over the time necessary for ameliorating the multiple needs of ex-patients.

Moreover, the well documented fact has to be faced that the more severe, the more chronic, and the more complex the problems, the longer it takes and the harder it is to implement constructive changes.

Thus, two requirements lie at the very heart of effective psychiatric rehabilitation: (1) the formation of versatile teams specialized in developmental aftercare techniques, and (2) the ability of such teams to obtain fees for services through existing social welfare channels which will enable them to provide continuing services as long as necessary.

The purposes of RECOVER were to investigate team approaches to providing comprehensive services and to explore possibilities for program survival in a world indifferent to ex-mental patients.

Findings

The Team: After trying several models of team organization, one that met client needs most efficiently evolved. Seven service personnel, one secretary and a clerk-steno comprised the staff. One person was program coordinator and part-time counselor; two were counselors and group therapists with one of these responsible for education; another was counselor, coordinator of special client groups and activities and recreational specialist; the fifth was job-sampling coordinator, vocational specialist, housing coordinator and community liaison person; the remaining two were paraprofessionals trained through the Community Mental Health Expediter Project as community resources specialists, field workers and interviewers.

Each of the two full-time counselors worked closely with an Expediter forming two mini-teams. Counseling and groups were conducted by the counselor while the Expediter took care of all arrangements with community agencies, necessary transportation and home visits; counselors also served as consultants for Expediters. Both mini-teams met regularly with other staff responsible for education, vocational experiences, housing, recreation and special client groups. These people knew all clients and clients knew them. The coordinator monitored services for each client to assure continuity.

The combined efforts of these people constituted the mechanism whereby multiple services were obtained and coordinated. Many of the services themselves, however, were provided by other agencies.

Two obvious advantages accrued from this approach: (1) Several different types of expertise and specialized knowledge were brought to bear on the particular combination of needs of each client. (2) Every relevant service and benefit the community offered was made available to clients without red tape or hang-ups and with necessary support and practical assistance.

Program Survival: A well coordinated program of comprehensive services in many ways can enable clients to avert failure and gain in coping ability. But the process is often slow and requires periodic reinforcement. Therefore, it is equally important that a program develop means of surviving. RECOVER accomplished this by joining with a progressive mental health center and carefully defining its services to meet requirements for obtaining case costs from the Division of Vocational Rehabilitation and fee payments under Title 19 of the Social Security Act.

Outcome: In terms of conventional indices, Graduates of the program fared as well as those of the most successful programs reviewed. Eighty-nine percent males and 82% females remained in the community for one year without rehospitalization. Both groups spent five times less time in the hospital during the follow-up year than did members of all other groups with which they were compared. Likewise, 72% males and 69% females were

employed six months or more during the post-program year. Graduates showed significant improvement in social functioning as measured by the Major Life Areas scores. There was also evidence that their self-concepts improved in that they became less defensive or less self-derisive depending on which type of self-description characterized them at intake. The majority were judged by staff to have attained objectives developed with counselors to a moderate or better degree. The majority also were seen by staff as having made tangible gains over the follow-up year.

In light of many other studies concerning the permanence of rehabilitation, however, we doubt that these gains will persist indefinitely without periodic reinforcement and assistance through the inevitable ups and downs.

Costs and Savings: A team such as RECOVER costs about $80,000 a year. Taking account of the average, relative reduction in rehospitalization, the number of people taken off welfare and gains from taxes paid by former clients who worked, we estimate that the saving would be in the vicinity of about $92,800 a year for 70 graduates, or $12,800 more than it costs to operate the program. Humanitarian benefits, of course, are incalculable.

Final Impressions: Several researchers estimate that between 50 to 75% of ex-patients require more servies than are currently provided to survive in community life. With many of these people the little things such as poor living arrangements, loss of a job or misunderstanding with welfare, lack of supervision in medication, or just the frightening emptiness of their lives trigger off disturbances that send them back to the hospital and further substantiate the belief they are hopeless cases.

Agencies, or preferably specialized teams, are essential to provide human relationship, crisis intervention and help over the rough spots for these fragile people who are otherwise often essentially abandoned. As NIMH's Dr. Mosher pointed out, "A complete understanding of schizophrenia still eludes scientists." It is difficult to imagine that those who never had or lost their ability to lead effective lives will someday be saved by a scientific breakthrough in biochemistry or by invention of a super technique. The social worker-nurse, psychiatrist teams of Holland and the Soviet Union, similar approaches in Scandanavian countries and many programs in America, have shown that patient, persistent care for these people can benefit them, often to an extent hard to believe.

RECOVER has demonstrated an approach to organizing a multiple service team and obtaining fees that make survival possible. Our most important finding is that it can be done.

ACKNOWLEDGMENTS

RECOVER is like an organic garden. It had to be laid out, planted and cultivated but it could only grow with adequate soil and nourishment and a concomitant, interacting ecological system.

The initial soil was provided by the Washington State Office of Research of the Division of Institutions, the applicant agency at the outset. Dr. William Conte, former Director of the Division of Institutions who has a keen awareness of the dirth of aftercare and rehabilitation in the mental health area, gave the program the essential support of a major State agency. Dr. Audrey Holliday, former Administrator of the Office of Research, implemented the support.

Essential sustaining nutriment came from the Division of Research and Demonstration Grants, Social and Rehabilitation Service, Department of Health, Education and Welfare. The project as a whole and the Director, personally, are especially grateful to Mr. Nathan E. Acree, Executive Secretary, General Research Study Section, for his invaluable assistance and support through the many vicissitudes and growing pains encountered along the way.

Once the program took root and began blooming, it encountered the double holocaust of a major State recession and bureaucratizing all social services into one superagency with a preformulated system of priorities. As in the nation as a whole, aftercare and rehabilitation services for the mentally ill did not even enter the ranks of priorities. The plan was to plow the program under. Three factors saved the day: (a) The staff held firm, tightening belts and donating services where needed; (b) Mr. Acree somehow kept the grant alive in Washington; and (c) New soil for a transplant was provided through the efforts of Dr. Allen Ratcliffe and the Comprehensive Mental Health Center of Tacoma-Pierce County which he directs.

Both before and after its near demise, RECOVER gained added strength by the loyal backing of the Tacoma Social Action Committee. This group tirelessly supported our effort to locate in the community and arranged for the program first to be housed in a building donated, rent-free, by the Allen African Methodist Episcopal Church and later in a larger house owned by St. Leo's Catholic Church. At our darkest hour, members of the committee, representatives of many community agencies, clients and interested citizens wrote to the Governor protesting loss of the program, all of which bolstered the effort to survive.

Once the transplant took effect, the program perked up as though nothing had happened and went on with its business of being fruitful. All that was lost was one year of the four-year SRS grant. Since it is our firm belief that aftercare and rehabilitation for the mentally ill have to be for as long as a client needs them, our next concern was to find the means for producing income that would assure the program's continuation. Since literally all our clientele were poor and welfare dependent (at least when they entered the program), there was no hope for support through client fees.

Here the Mental Health Center and the Division of Vocational Rehabilitation (DVR) entered. With aid from Dr. Ratcliffe and the Center's Business Manager, Milton Ploeger, the program developed a system for obtaining service fees for the disabled through Title 19 of the Social Security Act (Medicaid). In addition, David Hoffman and Steven Verhul of DVR provided invaluable help in negotiating fees for services for clients (or services) not eligible under Title 19. Primarily through these sources, RECOVER will be able to continue growing itself and thereby contribute to the continued growth of its clients.

Equally vital to the program's health have been the multiple contributions of community agencies, Western State Hospital, schools and colleges, the many businesses and organizations that provide job-samples, volunteers and students.

To all these ecological agents we extend our most heartfelt appreciation.

The essence of a program is the staff. RECOVER's vitality, stamina and humanistic-inventive nature could not have been without the unique personalities that comprised its staff. Altogether 22 people participated as paid staff in the various phases of the program's development.

Three who began from the beginning and are still with the program have been the backbone; they are: Paul Gergen, Coordinator, Leon Tibbetts, Counselor, and Ina Rattenbury, Secretary.

While the State was still contributing, in addition to Ina, Lori Trueblood and Terri Blackwell typed, filed, phoned, reminded and nurtured us (secretaries and typists have very dynamic roles). Elda Silvestri, Vocational and Community Resources Specialist, and Richard King, Counselor, Recreation and Education Coordinator, were with the program for most of its duration. Our two Expediters, Edna Foot and Idella Atkins, were and are integral to most activities of other staff and clients. Counselors who joined more recently are William Hasemann and Michele Hankins. Some of our staff during the beginning phase--Tom Reed, Scott Finley, Jackie Weiner and Vera Yager--were highly instrumental in helping us gain a clearer perspective of what we were about.

The research staff consisted of Craig Delbridge, Loretta Martin and myself at the outset. Palmer Irish and Dorothy Kinney worked for nearly a year ferreting out data from the comparison sample. But belt tightening and adaptations tend to fall first on the vulnerable research staff. Loretta and Craig were lost to State priorities. Joe Mallon filled in for a while and then Don Ayers joined us. With the backing of our secretary, the voluntary contributions of Marge Mires and help of Employment Supplement Program (ESP) workers, client job-samplers and the cooperative staff, Don was able to gather, store, retrieve and analyze our input, process and output data. Even after the grant and his salary terminated, Don helped tie up loose ends.

All of these people were members of the team (almost a family); they believed in what they were doing and did it.

H. J. Wahler, Ph.D., Director

I. REVIEW OF OTHER PROGRAMS

Rehabilitation is somewhat unique among the social and health services. Mainly it deals with what lies beyond treatment. After a physical or mental condition has been treated and improved to the extent possible, rehabilitation services may be called upon to develop skills and restore self-sufficiency--the major efforts are developmental.

Organized rehabilitation services have a relatively short history (Obermann, 1965). Aside from a few schools for the blind and deaf, rehabilitation did not become a national issue in America until World War I. From then until passage of the Vocational Rehabilitation Act of 1954, progress was spotty and slow. What services existed were for the physically disabled and primarily veterans.

Rehabilitation services for mental patients have been woefully lacking as attested by findings of the Joint Commission on Mental Illness and Health (1961). To this day such services for the mentally ill remain prominent by their insufficiency. The mental health centers as a whole have not met the mandate of the Joint Commission to provide "aftercare and rehabilitation [as] essential parts of all service to mental patients" (Wahler, 1971). The services that exist depend largely on the concern of state hospitals and a few philanthropic organizations.

One hope for the future lies in the attention given this problem by the Federal Social and Rehabilitation Services (SRS) Branch of the Department of Health, Education and Welfare. For over twenty years SRS has encouraged and supported a large number of rehabilitation projects designed to study and demonstrate ways of implementing and improving rehabilitation services for the mentally ill.

It is well recognized that enabling psychosocially disabled people to adapt effectively to a rapidly changing society poses a plethora of special challenges that call for approaches quite different from those developed for the physically disabled. It has been the hope that concepts and methods evolving from research and demonstration projects will sometime be effectively applied on a national scale.

RECOVER is one such R&D project. It has operated now for three years and this is the final report. Subsequently, assumptions, methods and processes of the program will be described. This will be followed by a somewhat detailed description of assessment methods and the findings of evaluative research. But prior to looking at the project itself, other projects addressed to similar problems will be reviewed. Ideally, the intent of such a review would be to convey a comprehensive overview of what has been done in the area and its effectiveness. It was, however, not possible to neatly package the material reviewed into such an ideal overview. There simply were too many discrepancies in the reports regarding matters such as clientele, methods, settings and evaluative criteria. Nevertheless, it is hoped that the review will illustrate various approaches and highlight some of the problems inherent in the area.

Altogether 31 recent projects were reviewed but most information is based on 22 reports,* since 9 provided insufficient data for classifica-

*These references are marked with an asterisk in the bibliography.

tion or comparison. These projects were selected as representative of existing psychiatric rehabilitation programs and cover a wide range of content and methodologies.

In the reports reviewed, the primary objectives were addressed to improving clients' vocational functioning and enabling them to remain out of institutions. Holding a job and time-in-the-community were the primary criteria of success, although a third focus frequently mentioned entailed improved social functioning.

Clientele

First, it is of interest to consider what the clients of these projects were like; Table 1.1 summarizes various demographic characteristics of these people. It is apparent that the majority were unmarried males under 40 years of age. In terms of psychiatric history, they appear to have been chronic marginal functioners rather than "hard-core" chronic patients. One gains the picture of a group of fairly young people whose psychiatric problems periodically reach serious proportions, subside with treatment and then recur. Whatever the particular problems, they seem resistant to lasting change through traditional and even specialized forms of treatment (Criswell, 1968; Davis, Dinitz, Pasamanick, 1972).

Table 1.1

Characteristics of Ss Summarized Across Projects

Variable	Range	M	Median
Age	18-60 years	35	
Sex	43-100% male		65%
Education	9-20 years		12
Marital Status:			
Never Married	60-84%		65
Divorced, Separated, Etc.	76-93%		90
No. Hospitalizations/Client	1-3	2	
No. Years Hospital/Client	1-3		2
Diagnosis	53-100%)Schiz)		65 (Schiz)

While cause and effect are hopelessly obscured by the time patients reach rehabilitation programs, it is apparent they suffer from extensive interpersonal, social, behavioral, emotional and cognitive handicaps (Dincin & Swift; Miller, 1966; Neff & Koltuv, 1967; Paik et. al., 1966). Family ties are often broken as a result of the prolonged emotional and financial drain patients create for their families. The patients themselves tend to have poor or non-existent work histories and meager financial resources, which heighten their physical as well as psychological dependence on public agencies.

All this adds up to an indigent, isolated existence. When a patient enters the community, he leaves the shelter of the hospital. Without continued support, accumulated strength wanes to the point of collapse and rehospitalization. Psychiatric rehabilitation, then, is or should be an attempt through a variety of means to provide continued support and a gradual introduction of stress and responsibility so that shaky coping mechanisms will not be overwhelmed and gradually improve.

Services

While individual projects vary greatly in methodology, there are several categories of service that occur consistently (Rutman, 1964). Efforts have ranged from relatively uncomplicated, straight-forward programs with modest goals to complex projects offering more comprehensive services.

The traditional (and most common) approach has been to offer one or two services aimed at upgrading vocational functioning. More recently, however, the trend has been to recognize the need for an array of services concerning major life areas (Rutman, 1970; Silverstein, 1968). A thumbnail sketch of some of the most popular services is given below. For those interested, a more detailed description is available elsewhere (Gergen, 1970).

Work

A diagram of methods and their frequency in reviewed programs is given in Table 1.2. The specialized vocational components of projects have been separated into three basic categories: (1) in hospital; (2) sheltered workshop; and (3) community placement.

In-hospital programs were offered by 9 of the 22 programs as shown in Table 1.2. In only one instance did a program offer both hospital and community work placements. For the most part, hospital placements consisted of regular industrial therapy services with adjunctive programs such as token economy wards (Grimberg, 1970). However, a few projects included more services than are typically found in industrial therapy such as counseling, record keeping, planned assignments, shifts in placements and closer evaluation of performance (Paik, et. al., 1966). In the one project using both hospital and community placements, hospital work was used to assess performance prior to and as a contingency for work in community industry (Cohen, Fabrian & Geiger, 1969).

In 7 of the 11 projects offering community work programs, heavy reliance was placed on some form of sheltered work experience. In some

Table 1.2

Major Rehabilitation Methods and Frequency of Use Among 22 Projects

	WORK			HOUSING				SOCIAL	COUNSELING			
	In Hospital	S.W.	Comm. Place.	In Hospital	Supervised	Independent	Other or ?	Recreation	Individual	Group	Voc. Couns.	
Koltuv & Neff, '68		X					X		X	X	X	5
Grimberg, '70	X			X	X							3
Cohen, et. al., '69	X		X	X								3
Weinburg, '64	X			X								2
Brooks, '61	X			X								2
Buri, et. al., '72	X		X				X			X		4
Paik, et. al., '66	X			X								2
Sturman, et. al., '69		X	X		X			X	X	X	X	7
Tunakan, et. al., '70	X				X			X				3
Rutman, '70		X			X			X	X	X	X	6
Dincin & Swift		X	X		X	X	X	X	X	X	X	9
Schmidt, et. al., '69		X	X		X	X	X	X			X	7
Loether, '67					X			X				2
Bennett, '64					X							1
Gumrukcu, '65					X							1
LaFave, et. al., '65		X		X			X	X		X	X	6
Fairweather, et.al., '69			X		X							2
Daniels, et. al., '67			X	X								2
Berkowitz & Lurie, '66							X	X				2
Brodsky, et. al., '64	X							X				2
Castor & Kintz, '66	X							X				2
Bartholow & Tunakan, '67		X	X	X	X		X				X	6
	9	7	8	8	11	2	7	10	4	6	7	

cases, sheltered work constituted the major vocational service (Rutman, 1970). In other programs sheltered work preceded movement to more competitive settings (Sturman, et. al., 1969; Schmidt, Nessel & Malamud, 1969).

There are several types of sheltered employment. One is conventional sheltered workshops. Another type is exemplified by the Fountain House prevocational program (Schmidt, et. al., 1969) in which clients worked on various "crews" organized at Fountain House itself before beginning competitive community job placements. Work included clerical tasks, building maintenance, working in the thrift shop, and preparing and serving food in the Fountain House cafeteria and snack bar. These experiences were intended to help clients adjust or readjust work habits (e.g., attendance, punctuality, getting along with others) and gave staff supervisors an opportunity to evaluate performance and readiness for competitive placements. This procedure was also used at Thresholds (Dincin & Swift).

Since the ultimate goal of vocational rehabilitation is employment in community jobs, some projects used "job-samples" with community employers and businesses as an integral part of the rehabilitation process (Beard, Schmidt & Smith, 1963; Dincin & Swift; Sturman, et. al., 1969; Wahler & Marks, 1969). To set these up, contracts with employers were made by project staff who explained the nature and purpose of their programs. If employers were willing to participate, they agreed to have a client work on a temporary basis. With these arrangements clients' performance was supervised and evaluated in consultation with project staff. Depending upon the project, clients were not paid (Wahler & Marks, 1969) or paid by the project (Sturman, et. al., 1969), the employer (Beard, et. al., 1963) or both (Dincin & Swift). Typically, each project had many different "job-samples" distributed over a variety of job types and occupational categories. Usually clients were rotated among jobs in which they were interested and/or had aptitude.

Job-samples were usually not intended to serve a direct training function. Rather, they were used more as situations in which personal problems related to vocational functioning could be confronted and resolved (Beard, et. al., 1963). They also provided an experiental base upon which vocational plans could be developed.

The methods outlined above emphasize programs individually tailored for each client. Each client's progress, functioning and output was not dependent on the performance of others. A different tack was taken by other investigators (Daniels & Muldau, 1967; Daniels, Zelman & Campbell, 1967; Fairweather, 1969). This consisted of patient-operated small businesses organized in such a way that task performance depended on group effort. For example, Daniels, et. al., (1967) formed a house-painting business where all the work was done by patient-teams. This created a condition in which cooperation and support among team members was essential for successful performance. Also, since customer satisfaction was necessary for continued operation of the business, strong group pressure was exerted on members who failed to conform to group policy.

Housing

A look at Table 1.2 shows that some form of living situation was provided for by 20 of the 22 projects. Of the 15 projects, 5 provided programs for people while they were in institutions and 10 served people living in the community. Only 2 of these projects offered programs to people that were either in or out of an institution.

Supervised living arrangements in the community took several forms. Among the most popular were halfway houses. The simplest approach was merely to provide a facility where a group of ex-patients could live together and in the process support each other in their efforts to regain self-sufficiency. Some halfway houses were open only to ex-patients (Loether, 1967) while others endeavored to have ex-patients and non-ex-patients live together (Bennett, 1964; Gumrukcu, 1965).

Contrasted with these unstructured, loosely organized halfway houses were those with highly structured, comprehensive programs offering opportunities, training and services in vocational and social adjustment, and in recreational and leisure time activities (Horizon House, 1966; Sturman, Worley, & Forster, 1969). Typically, professional staff were actively involved in the program and provided regular individual and group counseling for residents. One such program, Horizon House, operates a duplex which serves as a halfway house, an industrial workshop, and a social, vocational, recreational and counseling center. The halfway house per se is only one facet of such multiplex programs.

Taking an overall view of housing arrangements associated with various programs, halfway houses constitute middle-range accommodations. For clients needing little or no supervision other methods are popular. Tunakan, Van Fleet and Schaeffer (1965) placed clients in community boarding houses while Fountain House leased several apartment units which they then rented to clients. In both cases, the project was only indirectly involved in supervising living quarters. At the other extreme is the need for residential facilities with comprehensive programs for people who cannot survive in the community without close supervision and considerable guidance and support. Such intermediate care programs specifically designed for ex-patients are still largely in the planning stages (Meislin, 1969).

Socialization

As noted above, the primary emphasis in rehabilitation historically has been vocational. However, it has been recognized for some time that with psychiatrically disabled people, the major impediment to successful vocational functioning, and for that matter independent living in general, is social inadequacy. Thus, efforts have been made to develop methods for improving social functioning.

Programs intended to improve social behavior seem to be quite similar whether conducted in or out of hospitals (Brodsky, Fischer & Weinstein, 1964; Castor & Kurtz, 1966; Dincin & Swift; Gumrukcu, 1965; Rutman, 1970). Characteristically, an informal meeting place or lounge was provided where clients could talk among themselves, play games, sing and engage in other casual activities. Usually a series of organized meetings also were

arranged such as special interest groups, discussion groups, social clubs, outings (e.g., picnics, camping) and classes in topics such as cooking and money management. Such activities typically were conducted within the "walls" of the project.

While it was hoped that effects would generalize to the larger community when clients left the programs, there was seldom any attempt to involve clients with people and activities in the community, where sustaining relationships might develop. Burkowitz and Lurie (1966) made such an attempt in a program which revolved around a community center. Apparently it was a place where non-ex-patient community members gathered to participate in special interest groups and community projects. The program provided a four-stage entrée. Phase 1: Patients were introduced to the center while still in the hospital. Phase 2: When first discharged, they began by participating at the center in activities exclusively for ex-patients. Phase 3: They then proceeded to groups composed of both ex-patients and non-patients. And, finally, Phase 4: Ex-patients severed all ties with the project and participated on their own. This type of program seems like the next logical step in the progression of socialization programs.

Individual and Group Counseling

The majority of projects provided individual and group counseling in addition to other services. Counseling was typically intended to implement effective utilization of other services rather than constitute treatment of psychiatric disorders. The emphasis tended to be on difficulties in adjustment and relearning associated with areas that were the main focus of the program. The counselor was seen as a person to whom a client could turn for help in finding ways to cope with unfamiliar or troublesome situations and who could make suggestions and offer guidance in planning for the future. Perhaps of equal importance is the fact that for many clients the counselor may have been the only person they knew who was genuinely interested in their progress, development and well-being.

Program Evaluation

Program evaluation of research and demonstration projects is a two-sided proposition. It is intended to determine the effectiveness of project efforts vis-a-vis some criterion as well as contribute to a pool of information by which methods and techniques can be refined and knowledge advanced. Our review leads to the conclusion, alluded to by others (Kendel & Williams, 1963), that with few exceptions evaluation efforts have not contributed substantially to either of these goals. There are two principal problems: (1) research design and (2) data analysis. Both suffer from lack of standardized measures, criteria and objectives.

Research Designs

In order to make inferences, we must make comparisons.* The closer the equivalence of comparison groups the stronger the inferences that can be made from demonstrated differences in dependent variables. Random assignment of subjects to groups is the preferred method of achieving equivalence.

*Campbell & Stanley (1963) give a detailed discussion of the issues raised in this section.

Table 1.3 lists six research designs arranged in ascending order of adequacy and gives the number of projects using each.

Table 1.3

Research Designs and Frequency of Use for 22 Projects

Design	F
Multiple group comparison - random assignment	4
Multiple group comparison - random & non-random assignment	2
Multiple group comparison - no random assignment	0
One group - pre-post-comparison	4
One group - no comparison	12

It is apparent from Table 1.3 that the two most adequate designs have the least representation. The most frequently used procedure (one group - no comparison) is technically not a design at all since it does not rule out alternative explanations of effects and allows no comparisons. While it is probably not possible to ensure no-treatment control groups (Fiske, et. al., 1970), it is possible to find people who have not had the experimental treatment and who are at least similar to E groups in important respects. Comparisons between E groups and such semi-equivalent groups shed some light on trends and are better than none at all.

Another important consideration is the fact that adequate research can be more easily conducted by some projects than others. Projects that are part of well-established, community-based organizations in major metropolitan areas or part of large institutions should have access to large numbers of subjects. This makes larger samples, control groups and randomization much more feasible than is the case with smaller organizations, those in smaller communities or programs starting from scratch.

The unavailability of trained and experienced researchers and the money to pay them is another serious problem in agencies large or small with a service focus.

Data Analysis (Outcome)

Comparing outcome data across projects to establish trends uncovers further disappointments. These are nearly always linked with lack of uniform standards in: (1) criteria of improvement; (2) definition of criteria; (3) length of follow-up periods; and (4) method of reporting. Where such standards are missing, there is usually little to be salvaged but a number of percentages, which often are not comparable* between projects.

*Kendel & Williams (1963) note other areas of inconsistency such as specification of objectives and theoretical guidelines.

Table 1.4 gives the criteria used by the 14 projects that listed their criteria. It may be observed that one source of agreement lies in the importance placed on employment and community residence; however, it is discouraging to note that these were the only two criteria on which such agreement existed. Furthermore, projects seldom agreed on definitions of criteria. For example, even a "common-sense" variable like employment was defined in a wide variety of ways. Over various projects definitions ranged widely from only those who worked full time in competitive jobs to any clients who had some work experience whether part time, temporary, paid or unpaid. It is not surprising, then, that employment outcome rates covered a wide range.

Table 1.4

Criteria of Success Among 14 Projects

Criterion	No. of Projects	No. Using Combination of Criteria						
		7	2	1	1	1	1	1
Employment	13	X	X	X	X	X	X	
Living Outside Institute	12	X		X	X	X	X	X
Psychiatrist Judgment	1					X		
Pre-Post Difference in Questionnaire Scores	1			X				
Personal Adjustment	1				X			
General Social Function	1				X			
Participation in Activities	1			X				
Staff Ratings	1						X	
	Subtotals	2	1	4	4	3	3	1

A similar situation existed with community residence. In some projects a return to the hospital while on the program or during the follow-up period constituted a failure. The most common method, though, was to count as successes those living in the community when follow-up data was collected.

Wide variation in length of follow-up intervals further confuses the issue and makes comparison of results less meaningful. Table 1.5 lists outcome statistics on the two major criteria for three follow-up periods. The percentages of Ss employed according to various standards ranged from 21 to 70% with a median of 43% across all follow-up periods. For community residence the range was 40 to 88% living outside an institution with a median of 70%. In all cases where control data were available, E groups exceeded C groups in rate of criterion attainment. However, with the relatively small Ns involved and differences in criterion definitions, the clearest inferences that can be made from these data are: (1) that more people stay out of the hospital than are willing or able to work; (2) rates of community residence are more stable than those for employment; and (3) participation in projects seems to help. It is not possible to draw conclusions regarding durability of effects from the available reports, since projects were seldom funded long enough to conduct protracted follow-ups. However, as mentioned earlier, other sources indicate they dissipate with time (Criswell, 1968; Davis, Dinitz, Pasamanick, 1972).

Table 1.5

Outcome Statistics for 14[a] Rehabilitation Projects in Terms of 2 Major Criteria

Follow-Up Period	No. of Projects	N Range	N Median	% Employed Range	% Employed Median	% Living Out of Institute Range	% Living Out of Institute Median
0-6 Months	5 (1)[b]	40-133	70 (67)	26-63	45 (28)	56-88	74 (45)
7-12 Months	2 (2)	60-100 (38-50)	80 (44)	56-70 (42-50)	63 (46)	65-75 (59-61)	70 (60)
18-24 Months	4 (2)	32-200 (19-38)	105 (29)	21-50 (0-46)	36 (23)	24-85 (16-42)	68 (29)
Unspecified	3	53-133	120	39-53	41	69[c]	69
				Median	43 (28)	Median	70 (45)

[a] This type of information was available for 14 of 22 projects.
[b] Numbers in parentheses are control group data where available.
[c] Two projects in this category reported 69% of follow-up cases living in the community. One project did not give this information.

In general, lack of standardization creates a serious impediment to building a base of knowledge. While it is undesirable to hamstring researchers with imposed research designs, it would seem wise to establish minimum design requirements including standardization of basic measures, criteria and follow-up periods. Until some standardization is achieved, comparison of results across projects will continue to yield only tentative and tenuous information.

2. OVERVIEW OF THE RECOVER PROGRAM

The purpose of the RECOVER Project as stated in the original proposal was "to develop, demonstrate and evaluate a system of comprehensive rehabilitation methods for 'special problem,' chronically unemployed people...with special emphasis on revolving-door [ex-mental] patients."

The objectives were to demonstrate:

(1) that people with emotional, mental and social handicaps require specialized rehabilitative help;

(2) such help must consist of integrated systems of many services aimed at facilitating personal growth and actively engaging clients and community reciprocally in the growth process;

(3) more "marginal" people are "saluable" than has been thought traditionally and the earlier a specialized rehabilitative process begins the higher the probability of success.

The methods to be used were:

(1) carefully screened and supervised residential facilities

(2) individual counseling and problem-solving group sessions

(3) job-sampling opportunities

(4) training in career development skills

(5) general and vocational educational opportunities

(6) training and experience in leisure time utilization

(7) job placement

(8) follow-up and renewed opportunities.

Methods

For a program to be comprehensive it is essential that it have an array of services available in many important areas such as vocations, recreation, leisure time use, education, housing, and problems of daily living. In general, the more types of services the better. However, more important than a mere array of services is the way in which they are provided.

At RECOVER a distinction was made between services and service delivery. The first pertained to the services available both at RECOVER and in the community. Service delivery concerned the roles and organization of staff--how staff interacted with clients and other staff, how objectives were converted into action and how clients were encouraged to become involved. A basic assumption has been (and is) that the mode and spirit of delivery is even more important than the services themselves.

The following discussion will focus on both services and how they were delivered. But first a brief sketch of some assumptions that guided our approach.

Basic Assumptions

(1) Clients have deeply imbedded (habituated) emotional- social-psychological impairments.

(2) Manifestations of these impairments (confusion, fear, withdrawal, general ineptitude) are not merely passive reactions to a harsh environment, but are actively motivated, not necessarily conscious, attempts to cope and survive physically and psychologically.

(3) Generally, this behavior is oriented toward avoiding and resisting effects from the environment, particularly from other people, rather than seeking and striving to make the environment more responsive. Of course, infantile dependency and manipulation also occur as survival attempts.

To deal with these we assume the following are highly important:

(1) Dependable, non-threatening (not necessarily undemanding) relationships with other people are pre-requisite to reducing and perhaps changing the pattern from one of avoidance to approach.

(2) Activity opportunity types of services are most powerful if perceived by the client to be in his best interest--but not when seen as a means of pleasing staff or fulfilling project requirements.

(3) Most needed is engagement in a developmental process and time is the paramount factor. Directly applicable is the axiom that what took years to create is not quickly undone.

In short, we conceptualize the observed behavior as an ego-protective, avoidance oriented system fed by clients' beliefs or feelings that they may be unable to cope and hence every situation but the most familiar poses a threat of failure. Given this feeling of impotence and vulnerability, they are highly motivated to hang-on to whatever certainities they have. As a result, they become experts at resisting and sabatoging the positive efforts of helpers who "know what is best for them" (Ludwig, 1971).

For these reasons, we sought to avoid establishing rigid, formalized expectations and requirements. Instead, we tried to maximize individual choice and negotiation between client and program. The aim was to put the responsibility for improved functioning in clients' hands while we acted as facilitators. This laid the foundation for a particular kind of service delivery which will be described after a look at the services available.

Setting

When the project began, staff offices were in a research building separate from but located on the grounds of a state mental hospital. Since the program was aimed at released patients and the intent was to reinvolve them in the community, it became apparent that we needed to be in it. Through the cooperation of a local social action group, it was possible to move into a small two-story house in the central city at the start of the second year. This facility was soon overcrowded and a second move was undertaken at the beginning of the third year to a larger house also located in the central city.

Although much of the client activity took place away from the building, the atmosphere around the RECOVER house was an integral part of the program. It gave the program a warm, casual identity and the house itself provided an informal place for clients to gather. It also minimized the potential for developing doctor-patient roles. Our experience concurs with other workers (Dincin & Swift; Schmidt, Nessel & Malamud, 1969) who feel that the importance of settings cannot be overemphasized.

Services

Vocational

The mainstay of the vocational services was job-samples. These were volunteer work assignments which took place in businesses and agencies throughout the city. Employers were contacted and asked if they could use some free help and at the same time help a person who needed an opportunity for work experience. The program was explained in detail and employers were guaranteed the full backing of the program in case of difficulty, although no attempt was made to hide the fact that clients had emotional problems. Of the 96 employers contacted in three years, only one refused to cooperate. The range of potential job-samples was as broad as the employment base of the city.

The following are examples of the job-sample placements used by the project: teacher aides, park maintenance assistants, janitors, clerks, game farm attendants, service station attendants, sign painters, upholstery shop assistants, baker assistants, and hospital and nursing home aides. Although the majority of job-samples were unskilled labor, we were able to place clients with professional skills (two accountants and a registered nurse) in jobs requiring their particular expertise.

Job-samples were very flexible and consequently could serve several purposes. They provided: (a) opportunities for those who lacked clear vocational preferences to actively explore different types of work; (b) opportunities to strengthen work habits such as regular attendance, punctuality, getting along with fellow workers, accepting directions, and supervision; (c) informal on-the-job training; (d) a means of evaluating appropriateness of formal training plans; and (e) opportunities to use time constructively and to meet community people.

Unlike other projects (e.g., Sturman, Worley & Forster, 1969) the time a client was allowed to stay in any one placement was not limited and there were no requirements regarding the number of different placements a client must have had. Such constraints would have conflicted with our approach of implementing individualized client goals.

From time to time the job developer held seminars lasting from six to eight weeks. Sessions included practice in completing application forms, role playing job interviews, and discussions of matters such as job search procedures, appropriate dress and how to answer questions regarding previous mental problems. In addition, speakers from employment agencies and personnel departments came periodically to talk with clients.

Throughout the project close liaison was maintained with the Division of Vocational Rehabilitation (DVR). A mutual referral system was developed in which RECOVER clients were referred to the DVR counselor for vocational training and other services the program could not provide. DVR, likewise, referred clients to RECOVER for rehabilitation services.

RECOVER was fortunate to have a DVR counselor as liaison person who took a personal interest in the program. He gave us honest (but not always complimentary) feedback and was a strong advocate of the program among his many contacts.

Housing

When the project began, client housing was not sponsored by the program. In the grant application a halfway house was proposed but not funded and it was necessary to rely on supervised and unsupervised housing available in the community. This soon proved unsatisfactory on two counts: (1) supervised housing was poorly supervised and scarce, and (2) clients living in unsupervised accommodations were so widely dispersed they could not get together during off-program hours. This meant the loss of an important opportunity to capitalize on acquaintanceships made in the program.

After considering various alternatives, a housing service called cluster living was initiated. A landlord with four medium-sized apartment houses agreed to rent several apartments in each building to RECOVER clients. All the buildings were in central locations and rent was within the limits of welfare allotments. One RECOVER staff member lived in one of the buildings and agreed to intervene when and if problems arose. At first she was kept busy with questions, complaints, and crises from clients, but these gradually subsided as client self-help teams were developed.

From all standpoints, this arrangement proved very fortunate. A great deal of responsibility was left to clients--they were responsible for paying their rent, buying their food, and preparing their meals. This created a need for and a genuine interest in cooking and budgeting classes which before only elicited boredom. Clients' isolation was reduced, and they soon began inviting each other to dinner, shopping trips, movies, etc.

In addition to the benefit clients received, the project had no administrative or financial responsibility for buildings or their maintenance. However, as with job-sample employers, project staff provided 24-hour back-up to apartment managers, the landlord and clients.

During the two years cluster housing operated, there were several incidents. Some were initiated by clients (i.e., excessive noise, too many boyfriends) and others were generated by strict managers. Most of these were resolved with minimal staff involvement. On a few occasions clients were asked to leave by the manager and on one occasion the manager was asked to leave by the landlord. Although there were several incidents of psychotic behavior (some of which required rehospitalization), no client was evicted for this reason, nor did these instances create major disturbances. This was no doubt due to managers' quick notification of staff and an equally expeditious response from staff.

Current apartment managers are very interested in the program and the clients in their respective buildings. Once a month project staff and managers meet to discuss any difficulties that occurred and managers offer their services when appropriate. In effect they have become peripheral members of the rehabilitation teams.

Recreation and Leisure Time Services

This portion of the project went through several evolutionary stages. From the outset the intent was to involve clients actively in community social groups and events rather than merely give them something to do.

After several attempts and almost as many failures to interest clients in community recreational resources or special interest groups, it was decided to involve them directly in planning their own recreational and leisure activities. This was done by shifting clients with minimal need for individual counseling to a volunteer client-staff group. Positions in this group, known as the "Happenings Ensemble," were considered job-samples.

Under the direction of an imaginative staff member, clients gradually began to organize some fairly traditional but very successful activities and projects. For example, they updated a leisure time organization file consisting of over 300 entries; they instituted a monthly social evening, which was usually a costume party (e.g., Bohemian Happening) and a weekly crafts class which was conducted by a RECOVER graduate. A 130-page cookbook aimed at me preparation from low cost and commodity ingredients was compiled and at the time of this writing clients are trying to find a publisher. A "monthly" newspaper was started as well as a bulletin which appears whenever clients feel there is something urgent to say.

In addition to these "in-house" projects, clients themselves solicited and were given free passes or discounts to theaters, bowling alleys, miniature golf courses, swimming pools, baseball games and local fairs.

It is not meant to imply that clients spontaneously organized and decided to develop projects. This was not so. Neither did staff do most of the work with clients tagging along behind. The staff member provided organization, motivation, purpose and support. Clients faltered badly at first, but with continued re-emphasis that what they were doing was important for themselves and other clients and that they were the only ones who could do it, they gradually developed systems for getting things done. This process was implemented by the fact that better functioning clients supervised and assisted the more marginal people. In this sense, it was not unlike Fairweather's (1969) teams, although our group was less formally organized.

Besides building a leisure time program to be proud of, Happenings provided an additional sheltered work placement. This enabled us to assess and work more closely with clients needing special attention prior to community job-samples.

Education

In addition to informal courses and seminars held at RECOVER house, formal courses at local schools were also emphasized. These were viewed as another source of enriching experiences. Clients were urged to learn for fun rather than achievement and each was encouraged to take at least one course of his choosing while in RECOVER.

To facilitate this, the project maintained close liaison with the adult schools and community colleges as well as agencies offering instruction for high school equivalency diplomas. Current catalogues of course offerings were kept on hand and clients wishing to enroll were given assistance as needed. The project covered costs of tuition and books up to $100 per client--costs beyond that were obtained through DVR.

Individual Counseling

Each client upon acceptance was assigned a counselor. Assignment was most often based on size of counselor case load, although it was occasionally deemed necessary to make assignments by matching counselor skills with client problems. Clients met with counselors at least once a week for sessions lasting from a few minutes to an hour.

The counselor served a central role in the RECOVER approach to service delivery. He was responsible for coordinating the individualized program which he and the client decided upon. It was the counselor's job to keep clients focused on progressing toward the objectives they established. These objectives were seen as negotiable contracts between the client and the program which could be altered by mutual consent.

The term "counseling" rather than "psychotherapy" was used at RECOVER because we wanted to avoid a doctor-patient atmosphere. We wanted to emphasize that counselors (as well as other staff) were trained people helping other people learn how to steer their own lives and cope with practical problems arising therefrom. In the process, it was necessary to deal with therapeutic needs--emotional conflicts, interpersonal dilemmas, problems of self-concept, perceptual and thinking distortions, obsessive ruminations, etc. However, these were not treated as ends in themselves, but as impediments needing to be dealt with in the course of working toward carefully developed goals.

Groups

RECOVER utilized three types of groups: (1) small group, (2) encounter, and (3) self-help (large group).

Small Group: The small group had a traditional group therapy format with the focus on problems related to experiences in the program.

Encounter Group: The encounter group was for people who were well along in the program and who were judged by staff able to benefit from a direct-feedback approach. This group lasted from 8-12 weeks and was open to program and non-program members. Surprisingly, staff from several cooperating agencies joined. Contrary to common expectation, this was a very popular group among clients, and from our observations provided a useful experience.

Self-Help--The Levels System: Early in the program attempts were made to structure movement through the program into levels. The intent was to adopt a token economy concept to a community program.

A system with four levels was designed. The first three contained increasing responsibility, expectations, privileges and stipends. For example, on Level I a client could have a job-sample at the hospital (where we were then located) but not in the community. This level paid a stipend of 75¢ per day. On Level II clients were expected to have a community job-sample and earned $1.50 per day.

Level III was designed as a period for clients to make plans for graduation. This usually entailed looking for jobs, making arrangements for schooling or training and gradually disengaging from the program. The Level III stipend at $2.50 per day in addition to welfare grants was a relatively comfortable income for clients. Since there were insufficient funds for people to stay on Level III indefinitely and since we could not think of a strong positive attraction to the fourth stage of graduation and follow-up, it was decided to limit Level III status to four months. A graduated decrease in stipend was also instituted to provide a negative incentive for attempts to remain too long at Level III.

Client progress was reviewed each week and promotions were made as clients fulfilled the responsibilities of their current levels. This procedure worked very well for a while. A consultant specializing in behavior modification techniques viewed the program and felt major modifications were unnecessary. However, a curious thing began to happen. Clients progressed readily to Level II, but actively avoided Level III. It was soon realized that clients saw Level III as signaling a pre-determined termination date with a return of the many uncertainties they had experienced in the past.

Because we were unable to solve this dilemma, the Levels System was gradually abandoned in favor of a client self-help group.

Client Self-Help Group: The self-help group has met for approximately two years. Its intent was to convey expectations that clients were to do things for themselves; to generate opportunities and in the process enable clients to see that their actions could have effects. The group elected officers as well as a staff advisor who attended weekly meetings and acted as a liaison to other staff. The first major goal was to establish a loan fund and to defray expenses of entertainment which the group organized.

Their fund raising achievements were impressive, all things considered. For example, they arranged for a dinner-dance (spaghetti and a rock band), sold tickets, got a hall and band donated, bought, prepared and served the food, decorated the hall and cleaned up. The efforts of about 25 people were involved and the event netted $150. They also organized a flower stand which was open three days preceding Easter, Mother's Day and Memorial Day. Net profits were $350 for the three holidays. Other enterprises included two car washes ($85) and selling spices on consignment, which was their only break-even project.

With part of their earnings, the loan fund was established and rules, limits, and interest rates were adopted. The remainder of their funds paid for a campout.

With the advent of "Happenings Ensemble," the self-help group (named PROBE by clients) shifted major responsibility for fund raising and entertainment planning to the Ensemble and directed their attention elsewhere. They are now in the process of writing a constitution and planning an evening and weekend emergency service to help each other in case of crises. In time, it is hoped that this service can be extended to people in emotional crisis who are not RECOVER clients.

Although this group has had several successes, its evolution has been slow. Its progress is a mirror of its leadership. When the officers provide leadership, progress is made. When officers lack leadership ability, accomplishments wane.

Network of Community Services

In addition to services provided directly by the program, all relevant community services are made available and coordinated by project staff. In addition to other duties, three staff are responsible for maintaining current information on community social services. These staff provide close liaison between RECOVER and major agencies such as Public Assistance, DVR, the State Employment Office, the State hospital, and other components of the Mental Health Center.

It is noteworthy that in RECOVER we do not regard return to the hospital as a failure to be avoided at all cost. Quite the contrary, if a client showed signs of a returning psychosis, staff implemented his return to the hospital. However, we also kept in contact with the client and hospital staff which greatly facilitated early returns to the program where the client could take up where he left off.

Fragmentation and duplication which is often the result of multiple agency involvement did not occur. This was primarily due to the fact that: (a) RECOVER staff first enabled clients to clearly determine which services were needed; (b) staff were well acquainted with the full gamut of agencies and how they performed, thus avoiding inappropriate referrals; and (c) staff took full responsibility for seeing that clients received the services they needed. Clients were not just turned over to other agencies in hopes all would go well. RECOVER staff accepted responsibility for the total needs of the client and coordinated and followed through on all service needs whether provided by RECOVER or other agencies.

Follow-Up

Although average time for intensive involvement in RECOVER varied from six to nine months, the program was never closed to former clients. An important aspect of developmental aftercare, as we see it, is that clients have an option of returning to the program for complete or partial services as the need develops. The continued availability of the program over a long time period is necessary to maintain initial gains and keep the developmental process moving.

The Service Delivery Team

Having visited several of the more comprehensive psychiatric rehabilitation programs mentioned in the introduction, it is curious to us why so little is said about some of the "hows" of these programs--staff characteristics, staff-staff and staff-client relationships and administrative organization--all of which are very different from relationships and operations in traditional clinics and treatment agencies. Our observations and experiences led us to believe that if there is anything unique in psychiatric rehabilitation programs, it has as much to do with these intangibles as with the specific activities in which clients engage.

RECOVER embraces the often expressed philosophy that a client can best be served if he is treated as a total person. The "inner" psychosocial-emotional problems of clients interact with situations and situations in turn feedback upon the "inner" problems. Services must be available that can interact accordingly. This, of course, means knowing a great variety of things. One way to attempt this would be to require all necessary functions of each staff person. This is impractical for many reasons. A main one is that most people are not equally equipped to provide several types of service. For example, counselors are not trained nor usually interested in helping people manage everyday affairs. Vocational counselors may prefer not to deal with stormy emotional crises. Counselors, group therapists, psychiatrists, psychologists, etc., are seldom well informed about the many agencies, services and resources available in their community and so forth.

Another alternative is a team approach. This requires a great deal of communication, coordination, cooperation, flexibility and willingness to accept responsibility among staff who collectively represent a wide range of skills and interests.

Of course, there are teams and there are teams. The RECOVER team is a group of people working toward a common set of goals who possess complementary skills necessary for attaining the sometimes complex objectives developed by counselors and clients. Members of the team realize that their success will depend on their collective, integrated action.

Certainly not all people make good team members. Grob (1963) compiled the following list of qualities desirable for psychiatric rehabilitation team members: leadership, initiative, internal security, outgoingness, warmth, empathy for mental illness, tolerance for deviant patterns of behavior, objectivity, ability to set and adhere to reality limits for members, flexibility but consistency, freedom from dogma, conventionality or schematization in approach, courage to experiment with new ideas, capacity to maintain such effort in an inhospitable social environment, and ability to work in a complementary rather than hierarchical role.

While people with all of these qualities probably do not exist, the more of them found among staff, the better the team and the better the rehabilitation program.

The RECOVER team has gone through three evolutions. The first team was composed of a coordinator,* two counselors, and two community resource specialists. Their respective credentials were MS in Psychology, MA in Counseling, Mental Health Technician (paraprofessional, with 20 years experience, BA in Psychology, MA in Social Welfare.

The duties of the counselors were described in a previous section. The duties of the resource specialists were divided among the several community-oriented task areas. One person was responsible for job-samples, housing and liaison with the Department of Public Assistance and the State Employment Office. The other was responsible for recreational and social activities as well as coordinating the educational services. The coordinator, in addition to a small case load, maintained an overview of staff activity to insure coordination of effort and to see that the program functioned in accord with its goals. This entailed regular meetings with individual team members and the total staff. Support and back-up was given to staff when necessary and there were meetings with many agencies and groups to acquaint them with the program.

The second step in the development of the team occurred with the hiring of two graduates of the Mental Health Expediter Program (Wahler, Johnson, & Uhrich, 1972). This was a paraprofessional training program which focused on the practical and situational aspects of helping roles. Trainees were instructed in the fundamentals of counseling and problem definition. However, the major emphasis was on detailed knowledge of local social and health services and how to get them.

The Expediters formed a program called Community Outreach Rehabilitation (CORR), which was intended as a maintenance program for ex-patients who were unable to become fully involved in RECOVER but needed regular support in order to remain out of institutions. This program also served RECOVER clients who had received maximum program benefits, but who still needed minimal support to stay in the community. A proposal submitted to SRS for supplemental support of CORR was not funded which necessitated a third re-ordering of the team.

By this time RECOVER had accumulated a substantial waiting list and it was necessary to begin collecting fees for services in anticipation of the termination of federal funds. Up to this time, we had the luxury of being able to experiment with new methods without financial worry. Now it was necessary to maximize income without reducing quality of service.

To do this, staff were divided into two subteams. Each subteam consisted of one counselor and one Expediter. The two community resource specialists continued to function in the same way but related to two teams rather than to four individuals.

By pairing Expediters and counselors it was possible to give Expediters sufficient supervision so that they could maintain a small case load as well as help other program clients with everyday, practical and situ-

*The project director, a Ph.D. in Clinical Psychology, is not listed as part of the teams. While he kept in close contact with staff, he did not participate in direct service.

ational problems. They also began doing intake screening and acting as co-therapists in groups. This reorganization increased program capacity by approximately 75% (from 40 to 70 clients).

These three phases all contributed to a basic structure which promoted a fluid and dynamic quality in the program. There were no rigid policies, only guidelines. Any staff member, or client for that matter, could make exceptions to established procedure providing he was willing to accept the consequences. If consequences might potentially involve other staff, those likely affected were consulted or a group decision was made. All personnel selection and most major policy and procedural decisions were made by consensus.

Everyone had a voice in these matters which created an interest and responsibility for making them work. If, after reasonable trial, something or someone did not work out, changes were made by consensus.

Similarly, all staff had a voice in selection of clients. When a person was accepted that meant acceptance by the entire staff. Each had a responsibility to every client. Specific responsibilities differed among staff members depending upon the nature of their jobs, but there was, nonetheless, collective responsibility. Weekly joint team briefings were held so all staff had current progress reports on clients regardless of the team to which they were assigned. In the event of crisis in the absence of a counselor, someone was able and expected to help.

It was also program policy to listen to clients' complaints and suggestions rather than look behind their statements for "latent content" or assume their complaints were merely "sour grapes"--client input was regarded as valuable feedback for program planning. In order to enhance communication between staff and clients and to further legitimize client input, two representatives were elected from the PROBE group to attend weekly staff meetings and periodic intra-staff workshops.

Client welfare was paramount. From time to time it was apparent that a poor match had occurred between client and counselor and that it was to the client's advantage to be reassigned. New counselors sometimes had bruised self-images as a result, but when they saw experienced counselors exchanging clients it became accepted practice.

Throughout the course of the project every staff member from community resource people to the secretary was involved with clients. In cases where clients gravitated to inexperienced staff, close consultation and back-up was given by experienced staff. This flexibility and mutuality of effort did not happen easily. There were many fights. While the strength of the staff lay in its diversity (there were wide ranges of age, education, experience, value systems, personalities, etc.) reaching consensus among this group was often challenging. The fact that two people who sometimes disagreed on what should be done with clients had to depend on each other to do their jobs also created friction. Fortunately, all staff recognized that in a field where there are no clearly right answers, diversity and difference of opinion can become assets. This made it possible to establish ways of dealing with bad feelings that everyone came to accept.

This was done in two ways. First, two hours were set aside after the weekly business meeting to talk about and resolve problems between staff members. A communication-encounter format was used where the people in conflict tried to work out their differences with other staff observing and helping where necessary. This was not group therapy for personal problems. The problems had to be related to the work situation.

The second vehicle for dealing with interpersonal difficulties among staff and resolving program difficulties was reserved for occasions when several staff were cranky with each other. This was usually regarded as a symptom that there was trouble somewhere else in the organization. It often meant that we were becoming routinized, losing our focus and operating at cross purposes--for personal rather than group goals. At these times we held one- to three-day intra-staff workshops where everyone aired their complaints, feelings, and opinions about what was wrong and what should be done to correct it. The workshops functioned as general stock-taking sessions where we had a chance to take a breath and regroup. Three of these have been held at 8-12 month intervals.

The most vital question, of course, is what does all this have to do with clients? Two brief case studies may help to convey a flavor of what RECOVER was and was not able to do and how the team worked with individuals.

The first case is that of a woman who progressed considerably while she was in RECOVER. The first account is that of her counselor; the second is her description of her experiences.

Counselor's Summary Report--Ann (7-14-70 to 12-7-71)

Ann, an attractive 22-year-old female, referred herself to RECOVER after her discharge from the state hospital. This was her second admission, which was precipitated by depression and several suicide attempts. She had been treated with medication and electro-convulsive therapy as well as group and individual therapy. Her remission was slow and limited and she was still prone to recurring states of depression with a very poor outlook for her future. At the time she was interviewed for RECOVER she was somewhat obese and smoked incessantly; her reasons for suicide attempts were unhappiness, marital difficulties, and frustration over bills.

As her counselor, my first impression I must say, was quite pessimistic. She sat totally passive with no apparent expectation and with an unreal quality about her expression and affect. She was unable to initiate any conversation and her responses were short, blunted and had the effect of leading nowhere. She slumped in her chair, lit one cigarette from the other and waited. In spite of my own frustration and what appeared to be an almost utter contempt and disregard for herself, there was something about her that was appealing and I felt challenged. Her commitments which were negotiated during the first few months were: (1) She would keep her appointments with me. (2) She would involve me at the earliest possible time, day or night, if she became depressed, or otherwise got into difficulty. (3) She would cooperate with me, and my prescribed directions, as long as she did not disagree and that she would tell me if she disagreed.

Her initial objectives were: (1) to learn to get closer to people so she would not feel so lonely; (2) to understand and "make sense" out of her mixed-up life and her "weird behavior;" (3) to learn to like herself--"to be good;" and (4) to develop a vocational skill. Her objectives became our objectives. My commitment to her was to try my best to understand her and to do everything I could to help her achieve her objectives, as long as she continued to put forth an honest effort and wanted my help. That was and is our personal contract.

Prior to discharge from the state hospital she worked part time in the office as a ward clerk which she liked. As her first assignment, we arranged to continue this as a job-sample which she held for 2-1/2 months when she enrolled in the vocational school. She was also assigned to "small group" and to "large group" in addition to seeing me at first twice a week and later once a week for one-hour informal discussions.

The first 2-1/2 months on the program were fairly uneventful. Our relationship was developing some strengths and, except for a short while when she became threatened and complained that I was "too hard and pushy," we became quite comfortable with each other. She also liked the groups. In group she was allowed to be a passive participant--always invited but never pushed or expected to perform in any threatening way. In our session I could "call the shots" and if push was indicated, it was up to me to do it or arrange for it to happen.

By October, when she enrolled through DVR in a clerk-typist class at the vocational school, I had gained her trust and confidence and overall we had developed a good working relationship.

Aside from some initial anxieties, school went well and she managed above average grades. We began to see obvious positive signs of growth. Before this, progress, if any, was gradual and measured more by the absence of incidents or upsets than by positive signs. She now began to actively use the resources of the program. The expectations of school with its time limitations forced her to seek more aggressively the help she needed and to branch out to those who were qualified with the more specialized assistance she needed. Consequently, during this time she went to various staff and other counselors whereas before she stuck with me. She was also participating in a newly formed advanced Encounter Group and she had begun more normal dating practices, resulting from peer relationships at school. By February and March of 1971 she was receiving much feedback from others about the obvious transformation in her. She was active, outgoing and aggressive enough to meet most of her social needs. She had found a girlfriend whom she liked very much and was making plans for them to share living arrangements.

The negative incidents which did occasionally occur were played down and, more often than not, were not known beyond the counseling relationship. Her acting-out and drug abuse appeared to diminish in relation to her increase in self-respect. Only once did such behavior result in a return of previous suicidal feelings or threats. For a short period during a particularly stressful class at school, she developed a series of physical symptoms and complaints which reduced and leveled off when the stress passed. However, she apparently did retain a moderate degree of hypochondriasis as a means of coping under stress.

She enrolled in summer courses to expedite completion of her courses and also volunteered part-time work in the RECOVER Office. When she decided against returning to school in September, she continued on in this position until she acquired a temporary paid job with the United Good Neighbor Fund (UGN). While working in the RECOVER Office, she was elected President of PROBE, a self-help client organization, and was one of two who were elected to a second term.

Ann graduated from RECOVER in December 1971, while still employed at UGN. The decision to graduate was by mutual agreement between her and myself. She continues to see me periodically when she feels a need to do so. However, these visits appear to be, for the most part, social and include visits with other staff.

After her UGN assignment expired, she continued as a volunteer for about a month while seeking other employment. Unable to find office work, partly due to economic conditions in this community, she accepted work at a commercial laundry where she is still employed. She and her friend now live in a rented house in one of the better areas of the city, and it would appear from her occasional visits, that she is getting along quite well and is relatively happy.

Ann's Account of Experiences with RECOVER

Beginning the RECOVER Program in the middle of July 1970, I was frightened but hopeful. I didn't know what I wanted or expected from the Program, but I did know I needed help to stay out of the hospital. I decided to take a risk and see what RECOVER could do for me. I found out that the RECOVER Program could do nothing for me unless I was willing to help myself. My main problems were that I hated myself, liked very few people, and trusted no one.

The first three or four months on the Program were very hard. My counselor seemed to keep pushing me to talk about myself. At one time I wanted to change counselors because of this, but after talking to one of the other counselors I decided against it.

The pushing and probing and the way I was counseled finally paid off. I found out so many things about myself that I either didn't know or wouldn't accept. One thing I finally accepted was that I did get angry at other people. I always turned my anger toward myself and misconceived my anger as hurt. Also, I found out alot of things that I thought were abnormal were quite normal.

For months when someone would ask me a question I would answer "yes," "no," or "I don't know," giving only direct answers to their questions. My counselor explained that this was one reason why people felt I thought I was better than them, or thought I was a snob. He was right; when I started talking to people rather than just giving a direct answer, I got along much better with them--this really helped me.

The staff of RECOVER always gave me encouragement. They helped me get schooling through DVR, helped me with the parts of my courses I didn't understand and encouraged me when I was ready to give up on my

schooling. When I was President of PROBE, the self-help group, the staff encouraged me a lot when I was about to give up.

My job-sample was as a clerk-typist at RECOVER, which with the staff's help, built up my self-confidence and it made me feel good to know they trusted me to work with them and believed I could do the work. Like so many times before, when I wanted to give up they were there to talk to me and help me back up.

When my E.S.P. (Employment Supplement Program) slot was up at UGN, I couldn't get back on Public Assistance because they considered me employable. With help from the Program, I got back on until I got a job a few months later.

The RECOVER staff is like a big family, ready to help any client, at any time--day or night, who really wants help. Even the secretary helped if she could. Also, if my counselor was unavailable for me to talk to I could and did talk to one of the other counselors.

I honestly believe I would not have made it if it hadn't been for the RECOVER Program, the staff, especially my counselor who helped me help myself.

I was on the RECOVER Program about one year and five months, and I am very grateful that the Program and the RECOVER staff were always there to pick me up when I was falling, encourage me when I was ready to give up, and believe in me.

Even though I have graduated from the RECOVER Program, I can get counseling when needed, and take part in client meetings and activities.

Now, I have a job, plan to take more secretarial courses, have friends, trust people, and most important, like myself alot.

I still have my bad moments, but thanks to the RECOVER Program, I can handle them because now I believe in myself.

The following case demonstrates a less gratifying outcome. Unfortunately, Carl's view of his experiences is not available; he agreed to describe them, but they were not forthcoming.

Counselor's Summary Report--Carl (12-31-69 to 5-26-70)

Carl came to RECOVER with a great deal of confusion and fear about his sanity and much uncertainty and apprehension about his future. He was 18 years old, his parents were dead, his twin sister was in a state mental hospital, and he was totally alienated from his foster parents.

Carl lived with his parents until he was nine, when his father died and his mother abandoned him. His relationship with his foster parents was described as "distant" and their life nomadic. At age 14 he was committed to a residential school for juvenile offenders as a result of repeated runaways and numerous burglaries. There he graduated from high school and was released five months prior to our meeting.

In that five-month period he was arrested for carrying a concealed weapon with which he said he intended to assault his girlfriend's suitor. After his 15-day jail sentence, he admitted himself to the local state psychiatric hospital and said he was scared, nervous and depressed. He was intensely "worried" about his twin sister, who appeared to be the only person he deeply cared for, and was concerned that his sister's mental illness might be hereditary and that he might "have it."

Our assessment was that he was a bright, highly motivated person who was genuinely interested in getting himself out of his asocial rut. He was told that the Program could probably help him, but that any violent acting out would be dealt with swiftly and firmly and could possibly result in suspension. He agreed to this and re-affirmed his commitment to straighten himself out.

Carl began the Program enthusiastically. Since he showed high interest in recreation, his first job-sample was planning a recreational program for the patients in one of the hospital wards. He enjoyed the autonomy and responsibility, but when ward staff were slow to implement his program he became impatient and told them off. The bad feelings resulting from this could not be resolved and it became necessary to change his job-sample.

He was placed in the recreational department of the hospital and given responsibility for coordinating, scheduling and operating audio-visual equipment throughout the hospital. He was on this placement about three months and did very well for about six weeks. Then his performance began to decline both on and off the job.

By this time (about three months after entering the program) Carl had been involved in two incidents in addition to the altercation on his first job-sample. They all involved his defiant non-conformance to rules and resulting encounters with authority. Each time this occurred, he became more frustrated and seemed more prone to create further trouble for himself.

Counseling also became more and more frustrating. While the sociopathic qualities of Carl's behavior were apparent, it was equally apparent that he was genuinely trying to piece together a very fragmented identity. What was also becoming clear was that RECOVER did not provide sufficient structure for him to do this. I supported his striving, tried to empathize with his frustration and loneliness, warned him of consequences of further impulsive behavior, advised him on alternative ways of coping with potentially calamitous situations and encouraged him to come to me as soon as he felt he was losing his temper. The effects seemed minimal. His loneliness, worry about his sister, and sense of urgency and indecision regarding his future were overwhelming him.

We felt a more suitable living situation would be helpful (he was living alone) but when this was tried he fought constantly with others in the household.

Despite intensive counseling and excellent cooperation from all those working with him, Carl continued to decline. At one point he left with-

out warning for a California hospital to see his sister. Two weeks later he called his parole officers and wanted to return and readmit himself to the hospital. This was arranged and after two weeks he was discharged and readmitted to RECOVER. He began a job-sample as a teacher's aide at one of the nearby public schools, but within two weeks he committed a burglary and made threatening sexual advances toward two female RECOVER clients.

Sensing his impending suspension, he resigned from the Program. His sentence for the burglary was probation and he entered a community college after obtaining a student loan and getting a job on campus. Four months later he committed seventeen burglaries in one weekend and was sentenced to the State Reformatory where he served a two-year sentence.

During his incarceration he and I corresponded and he became interested in our plans to apply the RECOVER model to community correction projects. He was released to a halfway house a few days ago and is making plans to become involved in local prison and correction reform programs.

Although it is too soon to tell, we hope Carl will be an example that a failure is not always a failure. It is my biased opinion that he was actively trying to get into jail where he would be given the 24-hour care he needed. Hopefully, he has matured and may now be ready to give it another try.

Ann's case is a clear example of the apprehension and resistance that must be overcome before the more concrete experiences of the program begin to have the expected influences. It also emphasizes the importance of support and continued encouragement from other people.

Carl's case, like others which do not meet expectations, is frustrating. One is left wondering what the program was missing. What more could have been done; where was the key? Fortunately for Carl there was time to keep trying and time may be the most important variable.

3. PROGRAM EVALUATION: METHODS AND MEASURES

Methods, measures, conditions, and obtainable data in program evaluation always fall short of the ideal. The problems are well known and manifold. This study encountered most such problems and more.

From the standpoint of evaluation, three major problems were encountered: number of subjects, time and research staff. All of these were intertwined with the instability of circumstances in Washington State. About the time the program began, a major recession was developing. At the same time, the State government reorganized all social and health services into one comprehensive bureaucracy. The latter regarded rehabilitation of mental patients low in its priorities and withdrew support. This meant loss of both secretarial and research staff. Because of these events SRS also reduced the grant period from four to three years.

Although the program got off to a good start, we were at a disadvantage being located on the state hospital grounds and referrals from agencies other than the hospital were very slow until our move to the community in the second year. In our third (and last year as a research project) referrals had increased appreciably and we now have the inevitable waiting list. But many clients referred in the third year had not been out long enough for follow-up or were still in the program at the cut-off date. Altogether, 80 clients, both graduates and terminates with at least 30 days tenure, were our output for evaluation purposes at the cut-off date. When subdivided into groups of male and female graduates and terminates, the Ns are quite small. To make matters worse a number moved without forwarding addresses. Thus, at follow-up, attrition was considerable and especially troubling where Ns were small to begin with. Out of 50 graduates only 36 (72%) could be located for follow-up interviews (this despite regular contacts each month or two). Terminates were worse with only 18 out of 30 (60%) locatable. For both groups combined only 53 (66%) of the 80 subjects provided follow-up information. However, partial assessment of outcome was still possible in terms of data from hospital records and staff ratings.

Subjects

Since its inception to July 31, 1972, RECOVER received 461 referrals. Two hundred and twenty-five (49%) of these were accepted, 81 (18%) rejected and 155 (34%) were not assessed for a variety of reasons, such as failure to show up for appointments.

Client Selection

Following a few initial changes, the intake procedure was essentially as follows: After a briefing session, an intake interview was scheduled, requests for summary information were sent to referral sources and applicants were asked to complete four self-administering questionnaires. These instruments were to be completed by the applicant at home and returned at the interview. To obtain an objective measure of verbal functioning, the Shipley-Hartford was administered as a power test (without time limits) at the RECOVER Office.*

*Previous work has shown that the Shipley, thus administered, correlates at a high level with the WAIS Verbal Scale (Wahler, 1962).

The interview was guided by a semi-structured questionnaire which assured some uniformity to questions and the data recorded. The majority of people referred to RECOVER did not have involved relatives, but when family or others were concerned, interviews were arranged with them.

Information from the above sources was evaluated by the Selection Committee which decided whether applicants were to be accepted, accepted with conditions, rejected or whether further information was needed.* The decision to reject an applicant rested primarily on three behavioral criteria: (1) the amount of crisis intervention and/or support it was estimated the applicant would require; (2) the extent the applicant could participate in at least some aspects of the program; and (3) the degree to which an applicant would be disruptive to other clients. On this basis, people who were actively psychotic, prone to considerable "acting-out" or extremely limited in self-care ability were generally seen as unfeasible for the program.

Accepted applicants entered a one-month "orientation" phase in which they were further assessed on the basis of their behavior. Some dropped out, some were referred elsewhere, but the majority continued beyond the initial 30 days.

Data evaluated in this report were collected from September 1969 to July 31, 1972. Table 3.1 shows the disposition of all evaluated referrals during this two-year eleven-month period.

Table 3.1

Disposition of All Evaluated Applicants and Clientele

	REJECTED		ACCEPTED			
	Too Disturbed	Too Severe Management Problem	Graduates	Terminates+30 (Over 30 Days)	Terminates-30 (Under 30 Days)	In Program
M	27	19	19	13	12	16
F	20	10	31	17	24	27
Total	47	29	50	30	36	43

Categories in Table 3.1 are largely self-explanatory. Graduates are Ss who discontinued after they and counselors felt main objectives had been attained or that a point had been reached where they could benefit most, independently of the program. Terminates either discontinued themselves or were asked to discontinue before or after 30 days. "In Program" Ss were still active participants at the cut-off date.

*The committee was composed of the coordinator, senior counselor, a psychiatrist (upon request), the vocational specialist and a DVR counselor (for consultation), and two other staff members on a rotating basis.

Comparison Groups

Random assignment of Ss to experimental and control groups was not feasible, primarily because the case load during the first two years was too small to accomplish the purpose of random assignment--that is, forming two comparable groups for comparison. There could be no assurance of comparability with the very small groups that would have resulted. Furthermore, as Fisk, et. al. (1970) pointed out, a no-treatment control group is illusory. There is no way of assuring that when people are denied one type of treatment they will not obtain some other form of help. A partial solution to this dilemma would be to randomly assign Ss to two different types of treatment and compare the results. This approach also was not possible both because of the small samples and the fact that no alternative aftercare or rehabilitation program was operative in the locality. Therefore, an available group of ex-patients was evaluated and later matched with RECOVER Graduates for comparison purposes even if not ideal.

In addition to accepted and rejected Ss, samples of male and female patients not referred to RECOVER were interviewed one year after their discharge to the local county from the state hospital.

These samples, referred to as "Comparison groups," consisted of patients who were discharged between 1/1/69 to 8/31/69. Altogether there were 206 females and 233 males. Among these, Ss not meeting suggested guidelines for acceptance into RECOVER were excluded; e.g., outside age range of 18-55 and/or history of: organicity, retardation, severe character disorder, alcoholism or drug addiction. Among the 180 females and 195 males remaining, interviewers contacted and obtained information from 100 females (56%) and 50 males (26%). The number of people contacted was disappointingly low despite very thorough efforts to reach everyone. However, samples of 50 males and 50 females not contacted were compared with those interviewed in terms of the following variables obtained from hospital records: age, age first hospitalized, number of hospitalizations, education, marital status and source of financial support. None of these variables were significantly different, which suggests that unavailability may not have been a serious biasing factor.

After all data had been obtained for RECOVER clients, the Comparison samples were matched with clients on a group basis in terms of the following six variables:* age, marital status, education, diagnosis, number of hospitalizations and age at first hospitalization. Client and the original Comparison groups differed mainly in terms of marital status and age. More Comparison females were married and both male and female groups tended to be older than RECOVER clients. Thus, those eliminated were primarily older and married. In addition, Comparison Ss who subsequently entered RECOVER were also eliminated. Matching and elimination of people entering RECOVER reduced the number of Comparison Ss to 32 males and 40 females.

*Statistical tests for significance of differences between means or proportions of the six matching variables were all short of significance at the .05 level for males. With females only "number of previous hospitalizations" was greater for the Comparison group with a mean of 2.8 relative to clients' mean of 1.9 ($t = 2.7$; $df = 86$; $p < .01$).

Altogether five different groups were the basis for various types of "between" and "within" comparisons; namely, Rejects, Graduates, Terminates+30 and -30, and Comparison Ss.

Measures

One of the most difficult measurement problems in the social sciences concerns what to measure. Thinking in terms of a general systems approach (Longhurst, 1970), we were interested in the three areas of input, process and output. Where the primary focus of evaluation was on clients (in contrast to program methodology, organization, etc.) measures were needed that reflected: (a) salient client characteristics at input; (b) client involvement in program processes; and (c) changes at output. In addition, measures were required that could meet both service and research needs.

This all reduced to the following:

(1) Client characteristics at input required two types of measures: (a) measures of past functioning in major life areas, and (b) measures of how clients depicted themselves; e.g., Were they self-derisive or grandiose, frank and open, or suspicious and guarded? What did they complain of? What were their desires, needs, interests, and plans?

(2) Clients' involvement with program processes called for both records of what and how much they did and judgments of their investment.

(3) Evaluation of post-program (outcome) changes entailed not only measures but comparisons and inferences. Thus, it was necessary to have follow-up measures that could be compared with intake measures (to assess pre-post changes) and which could also be contrasted with groups that did not participate in the program.

Background Measures

Background information for research and service purposes stemmed from three sources: (a) semi-structured interviews; (b) a questionnaire completed by clients; and (c) hospital records.

Semi-structured interview forms and a Major Life Areas Questionnaire were developed for the program.* The intake interview form was designed to obtain information in the following 12 areas: education, *occupational history*, family background, *marital status*, *living situation*, *social activities*, *leisure time activities*, medical history, prehospital personal adjustment, psychiatric hospitalizations and treatment, social problems (alcoholism, drug abuse and social offenses), and current personal adjustment.

For the five areas italicized and a composite or total value, a scoring system was developed.** Because the interview was very time consuming, items in the above five areas were converted to a self-administering form

*Typical of many programs, we searched the literature for forms used in other studies but could find none that yielded the combination of information we deemed important.

**In order to simplify the respondent's task, questions were focused over the preceding one-year period. Information about extended occupational background was obtained in the interview.

called the "Major Life Areas Questionnaire" (MLAQ). The remaining items were collected into an abbreviated interview form which greatly reduced administration time.

Recently, most of the questions in the abbreviated interview form were converted to self-administering items and combined with the MLAQ. This latest form is entitled "Background Information" and the MLAQ items and scales are contained under the five italicized headings. This form is shown in Appendix A. (Program evaluation was based on data from the shortened intake interview form and the MLAQ.)

A process-reactive (P-R) scale was developed based on content of the Wittman-Becker P-R scales (Becker, 1956). Inter-rater agreement for the P-R scale has been consistently high with correlations between three pairs of independent judges ranging from .85 to .92. In addition, the brief self-report P-R scale developed by Ullmann and Giovannoni (1964) was given for comparison purposes.

Two employment indices also were obtained from intake information. These consisted of the percentage of time a person worked during three years and one year prior to applying for RECOVER. Employment was defined as work for remuneration except in the case of housewives or students. Only work outside the program (prior to or after) was considered. Time allocated to homemaking, training and part-time work also counted as employment in proportion to the time involved.

The majority of RECOVER clients had been state hospital patients even when referred by other agencies. The hospital records of in-hospital-time are very accurate and from these, time actually in the hospital (discounting time on leave) was obtained for three years (and one year) prior to beginning or applying for the program. For Comparison Ss, in-hospital-time was based on periods prior to the discharge date serving as a basis for follow-up interviews. Both time employed and time in the hospital were converted to percentages for the primary reason of reducing the magnitude of quantities concerned. In addition, proportions over one-year post-periods could be compared with proportions for either one- or three-year pre-periods with the same units of measurement.

Self-Description and Ability Measures

Questionnaires for obtaining information about clients' personal characteristics such as self-concept, needs, problems, interests and plans were administered (a) to provide information for counselors and (b) to provide quantitative records of such data.

From a service standpoint the self-descriptive questionnaires were regarded primarily as a standardized means of efficiently eliciting and summarizing clients' verbal behavior in specific areas. Three brief questionnaires were used: the Self-Description Inventory (SDI), Physical Symptoms Inventory (PSI) and FIRO-B; three longer instruments included the: MMPI, Kuder Vocational Preference Record, and Interests and Plans for the Future questionnaire (I&P).

A brief description of these instruments follows (excepting the MMPI

and Kuder, which are well known):

The SDI (Wahler, 1971) yields two scores. The fa score measures the degree to which people emphasize or de-emphasize (empirically derived and defined) favorable attributes; the uf measures their emphasis or de-emphasis of unfavorable characteristics.

The PSI (Wahler, 1968; 1972) measures the extent to which people complain of somatic symptoms.

The I&P questionnaire is an experimental scale which measures the strength of plans and adequacy of means (for implementing plans) in six major life areas: education, occupation, marriage, living situation, social life and leisure activities. The total score is considered a measure of planning ability. This instrument has proven highly discriminative between people who are apathetic and lack motivation in contrast to those who are goal oriented, alert and interested. For example, with repeated samplings, scores correctly identified between 80 to 96% hospitalized patients in contrast to college students.

The FIRO-B (Schutz, 1958) contains six brief Gutman-type scales that reflect the degree to which Ss express or want social inclusion, control or affection.

From the SDI and PSI we could infer whether a client was presenting a defensive, low self-esteem, symptom-claiming or depressive picture. From the I&P we inferred how adequately a client planned for the future and what plans and interests he spontaneously expressed. From the MMPI we gained an idea of how much a client stressed or denied various types of psychiatric symptoms. From the FIRO-B, clients' statements about social needs for inclusion, control or affection as expressed and wanted were summed up. And it was helpful at the outset to learn from the Kuder whether a client expressed strong interests in certain areas or simply had no prominent interests.

The Shipley-Hartford was used as a preliminary test of verbal ability. Most subjects scored in the average or higher range and no further ability testing was deemed necessary at admission. When assessment of abilities for vocational training or employment was required, clients were referred to DVR for such testing. If organic brain damage was in question the full-scale WAIS and Benton Visual Retention Test were given. If further questions emerged, clients were referred for neurological examinations.

The SDI, PSI, I&P, Shipley-Hartford and MLAQ (Background Questionnaire) were administered to all applicants not screened out on first contact. After an applicant was accepted into the program, the remaining questionnaires were given. Four of the instruments were administered a second time when clients left the program provided they had remained for at least 30 days. However, considerable difficulty was encountered in obtaining retest data and especially so in the case of terminates.

Staff Judgments of Clients' Assets, Deficits and Excesses

Two additional methods were employed to assess clients' personal characteristics. One entailed counselors' judgments of clients' assets and liabilities. The second consisted of determining clients' major needs by means of the "objectives approach."

The first method was developed over two phases. First, counselors were asked to keep records of what they felt was each client's major assets and liabilities. An asset was defined conventionally as any attribute, circumstance or material possession that would typically be considered valuable or beneficial to have. Liabilities were subdivided into deficits and excesses. Deficits were defined as lacking any personal characteristics or conditions generally considered desirable or beneficial to a decidedly disadvantageous degree. Excesses were defined as personal characteristics or conditions generally considered socially undesirable or deleterious when present to a degree that was handicapping or socially offensive. Counselors accumulated listings of these attributes for 86 clients over a one-year period.

For the second phase, these data were classified according to content and frequency and the various types of assets, deficits and excesses were then used as items to be rated on the basis of how much they were like clients. Altogether, there were 116 assets, 119 deficits and 118 excesses. Each item was derived from what counselors themselves considered relevant. The more frequently listed items and those judged most characteristic of clients will be reported subsequently.

The Objectives Approach

Several authors (Bloom, 1971; Druckers, 1961; Kroegler & Brill, 1967) have seen distinct advantages in counselors or therapists specifying their objectives in therapy from the standpoint of both treatment and research. The "objectives approach" was adopted early in the program to serve several purposes: (a) encourage counselors to conceptualize their goals for each client; (b) to provide a focal point for staff discussions of clients consisting of what counselors hoped to accomplish and how they were going about it; (c) to obtain information about clients' primary needs as seen by counselors; and (d) to systematically assess judged accomplishments with each client.

Counselors developed a set of objectives for each client. These were usually formulated during the first month or two of counseling but additions could be made as counseling progressed. Each objective was discussed with the client and in the large majority of instances both counselor and client concurred that the goals were pertinent and important. Typical objectives will be reported later.

Program Participation Measures

The degree of client participation in program services was assessed by two independent measures.

One method employed two 5-point rating scales. Staff members rated the amount of client participation in program services and activities on one scale. With the other they judged the quality of participation. Each staff member independently rated the clients he or she knew well, which ranged from 12 to 75. The score for each client consisted of the rating on both scales averaged over all raters. Correlations between pairs of the 6 raters ranged from .42 to .82 with a mean $\bar{r}$ of .64. The interjudge agreement, while not high, is sufficient to produce a relatively reliable average rating per client where at least three staff rated each person.

The second measure was derived from records of client participation. These included the average monthly number of negative incidents, counseling sessions, group meetings attended, and days on job-samples. The following measures also contributed to the score: final ratings of job-sample performance, number of educational courses taken and completed, the number of program sponsored recreational activities attended, and the client's type of living situation (i.e., whether client lived in a dependent, semi-dependent or independent setting).*

The latter measure was derived from distributions of raw data in each area; these in turn were subdivided into quintiles. Quintiles for each area were numbered from 1 to 5 and the sum of these was the composite participation score. This index correlated .61 with staff ratings of participation over 80 male and female clients combined.

Outcome Measures

Five measures were designed to reflect outcome. One was the percentage of post-program in-hospital-time obtained from hospital records. The second, derived from the follow-up interview, consisted of the percentage of time employed during the past-program year. The third, also from the follow-up interview, was the major life areas total score. The fourth and fifth outcome measures were based on two sets of staff ratings: counselors' judgments of objectives attainment and staff ratings of clients' general post-program gains.

The major life area total score (as an outcome measure of social adequacy) was based on data gathered by means of follow-up interviews based on items of the Major Life Areas Questionnaire rephrased for follow-up purposes.

The objectives attainment score is the average rating of attainment for each client's objectives. As mentioned, the objectives themselves were developed in the course of working with each client. After a client left the program. the counselor rated each objective for attainment on

*Staff who conducted these services were responsible for keeping attendance records, obtaining ratings and recording negative incidents. Standard forms were used for all these purposes. They were developed on the basis of practical considerations such as clarity, simplicity and appropriateness. Since these were merely record forms for collecting information systematically, it is felt they do not warrant discussion nor inclusion in appendices.

a 5-point scale.*

"Gains" scores were also obtained for each client as a measure of judged success. After Graduates and Terminates had been out of the program for about a year, staff members rated those they were acquainted with on two "gains" variables: (a) how much each person showed signs of personal, subjective gains or benefits and (b) how much each person showed signs of overt, behavioral improvement. Gains scores are the average of both ratings which in turn were averaged over all staff rating the individual. Average scores based on half the ratings for each person were correlated with means of the other half to estimate pooled interjudge agreement. This correlation over 79 pairs of ratings for male and female Ss combined was .76. Thus, the reliability of pooled ratings, while not high, is within acceptable limits.

---

*Anchors: 1. No Attainment (0-19%) 2. Very Little Attainment (29-39%)
3. Moderate Attainment (40-69%) 4. Good Attainment (70-89%)
5. Objective Essentially Fully Attained (90-100%)

4. MAJOR FINDINGS

Background Comparisons

Among Ss referred to RECOVER, those rejected were further classified in terms of the basis for rejection as "too disturbed" or as some type of "character disorder." The latter included people with histories of serious management problems related to alcoholism, drug abuse or social offenses. Accepted Ss were classified on the basis of whether they terminated after 30 days (+30), terminated prior to 30 days (-30), or graduated.

Basic demographic data for males and females in the preceding categories and Comparison groups are shown in Tables 4.1 and 4.2.

In general, information contained in Tables 4.1 and 4.2 clearly suggests that rejects, RECOVER clients (Graduates and Terminates) and Comparison Ss were all people with severe disadvantages; e.g., the majority in all three categories were: hospitalized several times, diagnosed schizophrenic, never married, divorced or separated, unemployed or only briefly employed and dependent upon public financial support.

Means and variances of the 5 MLAQ scores and total score for the above groups are shown in Tables 4.3 and 4.4 for males and females respectively.

As with demographic data, MLAQ scores of reject, client, and Comparison groups were generally comparable. None of the analyses of variance for testing differences between means over groups was significant. In contrast, differences between MLAQ scores of normal and all ex-patient groups were large and highly significant. The fact that measures of social adequacy are superior in normals is not surprising. The significant differences do, however, attest to the discriminative validity of the measures and the relatively poor social functioning of the ex-mental patients served by the program.

A correlational matrix for 9 background variables based on combined male and female Graduate and Terminate samples* is shown in Appendix B. These correlations are pertinent primarily from the standpoint of evaluating expected consistencies in the measures themselves.

In-hospital-time was inversely related to the employment index; the process-reactive (P-R) score correlated significantly with in-hospital-time and inversely with the employment index. MLAQ scores correlated significantly with other background measures in consistent directions: occupation and total scores were significantly related to the employment index and all MLAQ scores except living situation correlated in the appropriate directions with the P-R scale. Correlation between MLAQ total score and in-hospital-time was in the appropriate direction but not significant. The positive relation between total score and employment index and inverse correlation with the P-R scale were consistent with its interpretation as an index of general social adequacy.

*Because means and variances were not significantly different between males and females, and samples were relatively small, data from both groups were combined to provide a larger N.

Table 4.1

Demographic Information for
RECOVER and Comparison Groups; Males

		REJECTED		ACCEPTED			
		Too Disturbed	Character Disorders	Grads	Term. +30	Term. -30	Comparison
	N	27	19	19	13	12	32
Age	M	43	34	30	28	30	32
	σ^2	533	94	112	91	59	102
Education	M	11	12	12	11	14	10
	σ^2	6	3	9	2	4	3
% Time Employed Over 3 yrs pre							
	M	29	44	48	43	39	35*
	σ^2	860	1200	658	938	722	1428
No. Hospitalizations	M	3.7	2.3	1.8	3.4	3.8	2.8
	σ^2	7.6	4.0	2.6	2.5	5.8	3.9
Diagnosis:							
Schizophrenic		60	32	51	54	85	63
Depressed		9	10	5	15	0	9
Neurosis		7	0	5	0	0	6
Other		24	68	39	15	15	22
Marital Status:							
Never Married		71	37	58	38	82	69
Div. or Sep.		21	37	37	46	18	19
Widowed		4	5	0	0	0	0
Married		4	21	5	15	0	13
Source of Support At Application:							
Comp. or Welfare		65	79	68	77	90	34*
Parents		17	5	21	23	10	3
Friends or Relatives		9	11	0	0	0	0
Full or Partial Self-Support		8	5	11	0	0	63

*Employment and source of income for Comparison Ss is based on period one year after discharge.

Table 4.2

Demographic Information for
RECOVER and Comparison Groups; Females

		REJECTED		ACCEPTED			
		Too Disturbed	Character Disorders	Grads	Term. +30	Term. -30	Comparison
	N	20	10	31	17	24	40
Age	M	32	32	34	28	30	35
	σ^2	89	101	105	86	59	118
Education	M	12	9	12	13	11	10
	σ^2	1	6	4	2	1	11
% Time Employed Over 3 yrs. Pre	M	34	41	57	60	42	26*
	σ^2	1016	829	928	1152	1110	1358
No. Hospitalizations	M	3.3	2.8	1.6	2.5	2.0	2.7
	σ^2	5.7	5.0	2.6	3.0	2.5	1.7
Diagnosis:							
Schizophrenic		75	50	62	60	45	63
Depressed		0	0	12	20	24	15
Neurosis		0	20	5	7	8	10
Other		25	30	20	13	23	13
Marital Status:							
Never Married		55	30	27	65	30	28
Div. or Sep.		35	40	57	29	57	56
Widowed		0	10	6	0	0	0
Married		10	20	10	6	14	15
Source of Support At Application:							
Comp. or Welfare		75	70	70	64	48	51*
Parents		20	30	7	24	17	8
Friends or Relatives		5	0	0	6	9	5
Full or Partial Self-Support		0	0	23	6	26	36

*Employment and source of income for Comparison Ss is based on period one year after discharge.

Table 4.3

MLAQ Scores for RECOVER and Comparison Groups; Males

		REJECTED		ACCEPTED			
		Too Disturbed	Character Disorders	Grads	Term. +30	Term. -30	Comparison
Areas	N	27	19	19	13	12	32
Occupation	M	33*	37	37	37	32	38
	σ^2	56	31	48	62	126	99
Marital Status	M	37	40	38	38	32	37
	σ^2	45	64	33	50	27	85
Living Situation	M	39	41	40	39	36	39
	σ^2	54	73	37	37	18	22
Social Life	M	42	45	43	40	43	40
	σ^2	54	47	41	13	27	34
Leisure Time Activities	M	39	38	37	39	43	36
	σ^2	168	108	161	117	82	134
Total Score	M	33	37	34	34	33	33
	σ^2	82	45	32	34	10	54

*Employment and source of income for Comparison Ss is based on period one year after discharge.

Table 4.4

MLAQ Scores for RECOVER and Comparison Groups; Females

		REJECTED		ACCEPTED			
		Too Disturbed	Character Disorders	Grads	Term. +30	Term. -30	Comparison
Areas	N	20	10	31	17	24	40
Occupation	M	31*	32	44	34	34	32
	σ^2	25	55	274	33	58	31
Marital Status	M	38	40	40	38	43	40
	σ^2	44	89	35	98	102	60
Living Situation	M	31	35	38	37	40	41
	σ^2	75	89	99	100	108	43
Social Life	M	42	40	44	44	43	43
	σ^2	31	63	53	112	85	31
Leisure Time Activities	M	44	41	44	46	45	43
	σ^2	36	230	58	82	161	51
Total Score	M	30	31	35	37	36	34
	σ^2	40	131	55	81	75	40

*All scores are T scores based on scores of "normal" samples; all means for normals are 50 with a standard deviation of 10.

Within the MLAQ, interrelationships between scales were all low except social and leisure activities. Despite relative independence between scales, all scales correlated moderately but significantly with the total score. The social activities scale correlated highest (r = .64) with total score which also is consistent with interpreting the latter as a measure of social adequacy.

Correlations between background measures and conventional variables such as age and education were negligible. It is noteworthy that the P-R scale based on intake data correlated .41 with the Ullmann-Giovannoni self-report P-R scale which is within the range found by other investigators (Watson, 1969).

Self-Descriptive and Ability Test Comparisons

SDI, PSI, I&P and Shipley scores were obtained from both rejects and accepted clients. MMPI, FIRO-B and Kuder scores were available only for accepted Ss who had been in the program over 30 days. None of the "tests" were given to the Comparison groups. Tables containing average scores from the above instruments and the process-reactive scale are given in Appendices C-1 and C-2.

Again, correlations among the test scores are relevant primarily for evaluating the measures themselves. Because of the relatively small and varying number of subjects characteristic of this study, efforts to factor analyse or otherwise more closely examine properties of the self-descriptive measures would be of doubtful value. Therefore, in order to conserve space and avoid unnecessary digression into measurement analyses, the correlational matrix for these data will not be included.

The majority of Ss tended to describe themselves as inadequate, depressed or symptomatic in other ways although a proportion responded in a grandiose or defensive manner. The majority of Ss in the accepted groups obtained SDI fa scores that were lower than scores obtained by over 90% normal Ss; in contrast, the uf scores were higher than those of 80 to 90% normals (except for male Terminates+30). These findings reflect clients' general inclination to stress both deficiencies and symptomatic difficulties.

Consistent with this trend, all client groups scored high on the MMPI D, Pd, Pt and Sc scales as well as scoring high on the Un and relatively low on the De (the latter two scales are comparable to the SDI, uf and fa respectively). Both the MMPI Hypochondriasis and PSI mean scores were relatively low suggesting that on the average, clients were not emphasizing somatic symptoms.

With the I&P, cutting scores of 36 for males and 40 for females reliably differentiated between 80 to 96% of normal young adults from state hospital patients. The mean scores of all groups were close to or below these cutting scores, which indicate considerable deficiency in ability to plan and implement plans.

The process-reactive (P-R) scores range from 0 to a maximum of 47; as scores increase the implication of a process type background increases.

More than half of all groups except Graduate and Terminate+30 females had scores falling above the mid-point of 24. It may be seen in Appendix C-1 that all mean P-R scores lie at or above this mid-point except Graduate females. With subgroups combined, 66% Rejects, 55% Terminates and 48% Graduates scored 25 or higher. To the extent P-R scores indicate severity of pathology, these findings suggest that Rejects were the worst off with Terminates next and Graduates least. This implication is also born out, as may be seen later, by the fact that Rejects had spent the highest proportion of time in the hospital over a three-year pre-program period.

Despite these indications that Rejects were the most severely disabled, it is noteworthy that they did not differ appreciably from other groups in terms of self-descriptive scores.

The FIRO-B lacks standardized scores based on norms and is, therefore, difficult to interpret. Our scores consisted of percentile ranks derived from Schutz' student data. Except for male Graduates, the trend was for Ss to want more than they expressed of inclusion, control and affection.

Verbal IQs estimated from the Shipley-Hartford of all groups lay within the average range (90-109). The predominant interest of all groups as measured by the Kuder was in Social Service. It is also noteworthy that Terminates tended to score lower than Graduates in the first five interests but were higher in the Artistic, Literary and Musical areas.

One final point regarding self-description is sufficiently important to warrant mention. An interesting characteristic of a heterogeneous group is the diversity in self-concept and patterns of response to favorable and unfavorable content. Some Ss report multiple excellences and an almost total lack of problems or distress; others report few merits but also little distress; still others indicate both many assets and many liabilities. The majority, however, respond in a manner typical of mental patients--that is, they report a marked lack of assets and a heavy burden of liabilities. These different self-descriptive tendencies are especially apparent with scales measuring both assets and liabilities such as the SDI fa and uf scales* or the MMPI De and Un scales. Figure 4.1 illustrates the different response patterns discussed and also contains the percentages of RECOVER clients whose responses to the SDI corresponded to these patterns.

Consistent with the divergent response patterns shown in Figure 4.1, profiles of individuals on other personality instruments also ranged widely from extremely guarded or constrained to extremely self-derisive with the majority being of the latter type.

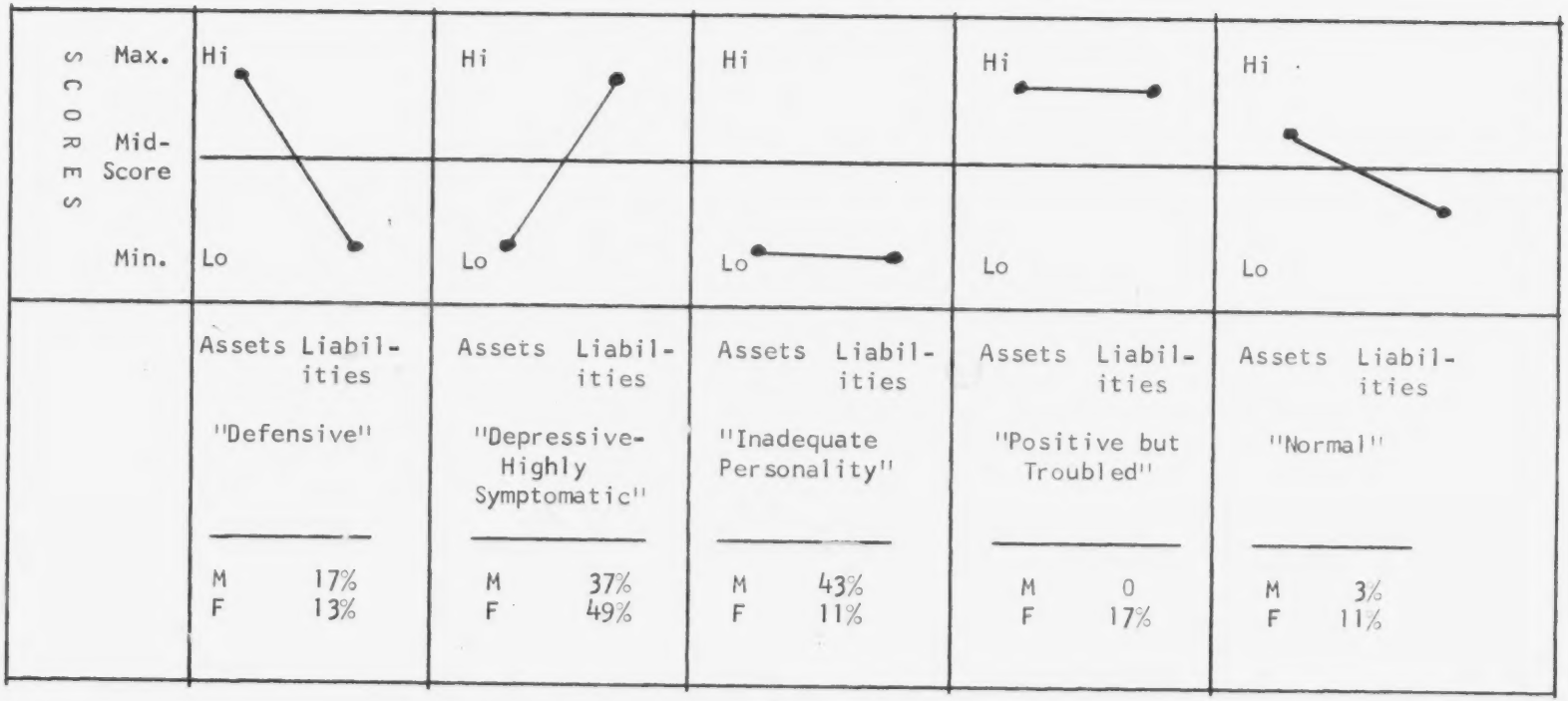
Counselor Assessments of Assets, Liabilities and Objectives

Client characteristics were also assessed by two additional methods: (a) staff judgments of clients' assets, deficits and excesses and (b) counselors' estimates of needs by means of the "objectives approach."

*Criteria for these types of classifications and their reliability are discussed in the SDI Manual (Wahler, 1971).

Figure 4.1

Types of Response to Personality Questionnaires



Assets, deficits and excesses rated as highly characteristic of clients are shown in Tables 4.5, 4.6 and 4.7 for Graduates and Terminates+30 combined.

From Table 4.5 it may be noted that counselors tended to see clients' assets as consisting primarily of good physical health, intelligence and, surprisingly, various social skills. In addition, about a fourth of the clients were considered well motivated. Competence-related assets such as self-confidence, good judgment, good organization, adaptability, good skills and abilities--assets related to potential for self-development and effective coping--were in most instances not seen as client attributes.

Deficits rated high by counselors tended to lie in areas of social functioning (although counselors also felt certain clients had social assets), self-concept and characteristics related to general adequacy.

Excesses were rated high less frequently than assets or deficits. Interestingly, aside from fear and panic with females, counselors did not stress conventional psychiatric symptoms as highly characteristic of clients and particularly males. At a personal level, excesses consisted largely of negative self-attitudes and tendencies. The most prominent excesses were in social areas such as negative social attitudes, dependence and objectionable social behaviors.

Taking into account both moderate and high ratings over all items (not shown in Tables) in each of the three areas, it is noteworthy that females were judged to have an average of 14.9 assets (to a moderate or high degree) and 8.1 deficits--1.8 times more assets than deficits. With males it was just the opposite. Males were seen as having 8.1 assets and 11.5 deficits on the average, or 1.4 times more deficits than assets. The average number of excesses for females was 7.8 and 6.5 for males. Apparently males were considered relatively less competent than females.

Objectives and their proportional frequencies are shown in Table 4.8; these evolved from counselors' work with male and female Graduates and Terminates. Altogether, there were 300 objectives for 72* clients with an average of 4.1 objectives per client.

The objectives in Table 4.8 were classified in terms of 6 main foci with 4 subcategories in the area of personal change. Objectives were also subdivided in terms of whether they aimed at <u>increasing</u>, (developing or improving) some capacity or condition in contrast to <u>decreasing</u> (toning down) some negative characteristic or condition.

The objectives developed by counselors undoubtedly would not be those valued by therapists of psychoanalytic or intra-psychic persuasions. Nevertheless, they are the kinds of here-and-now, relatively tangible needs counselors and clients saw as pressing and important.

*Objectives were not developed for 8 clients for several reasons, such as terminating shortly after 30 days.

Table 4.5

Client Assets*

	Males (N = 28**)		Females (N = 43)	
	N	%	N	%
I. Social Abilities and Conditions				
1. Good participation in social activities	-	-	-	-
2. Good family relations	3	11	5	12
3. Good social skills	13	46	26	60
4. Socially responsible	4	14	9	21
II. Aptitudes and Skills				
1. Good specific skills	-	-	-	-
2. Good general abilities - skills	-	-	2	5
3. Intelligent	6	21	16	37
4. Good judgment and reasoning	-	-	-	-
III. Motivation				
1. Well motivated	7	25	9	21
2. Energetic, hard-working	2	7	2	5
IV. Interests				
1. Many interests	-	-	-	-
2. Curious, adventurous	2	7	4	9
V. Personal Characteristics				
1. Good self-understanding	-	-	-	-
2. Able to help self	-	-	-	-
3. Self-confident	-	-	-	-
4. Adaptable; self-control	-	-	-	-
5. Good physical condition	8	29	16	37
6. Pleasant mood and outlook	-	-	5	12
7. Well organized, clear goals	3	11	2	5
VI. Background				
1. Good vocational experience	2	7	6	14
2. Good family background	-	-	-	-
3. Good education	3	11	4	9
VII. Material Conditions				
1. Financial stability	-	-	-	-

*The figures under N are the number of high ratings given by counselors. The percentages represent the relative frequency of high ratings in each area. Any one client may have had high ratings in more than one area. Hence the percentages do not total to 100.

**Assets, deficits and excesses were not obtained for some of the first clients to enter the program.

Table 4.6

Client Deficits*

	Males (N = 28)		Females (N = 43)	
	N	%	N	%
I. Social Abilities and Conditions				
1. Participation in social activities	5	18	6	14
2. Family relations	2	7	-	-
3. Social skills	11	39	9	21
4. Social responsibility	8	29	4	9
II. Aptitudes and Skills				
1. Specific skills	4	14	7	16
2. General ability - skills	4	14	2	5
3. Intelligence	-	-	-	-
4. Judgment and reasoning	3	11	2	5
III. Motivation				
1. General motivation	2	7	3	7
2. Energy	-	-	-	-
IV. Interests				
1. Variety of interests	-	-	-	-
2. Ability to seek new experiences	-	-	3	7
V. Personal Characteristics				
1. Self-understanding	6	21	-	-
2. Self-help ability	5	18	9	21
3. Self-confidence	11	39	29	67
4. Adaptability; self-control	5	18	5	12
5. Physical condition	8	29	3	7
6. Positive mood-attitude	2	7	-	-
7. Organization - planning ability	6	21	5	12
8. General adequacy	7	25	7	16
VI. Background				
1. Vocational experience	2	7	-	-
2. Education	4	14	-	-
3. Family background	-	-	3	7
VII. Material Conditions				
1. Financial stability	2	7	-	-

*The figures under N are the number of high ratings given by counselors. The percentages represent the relative frequency of high ratings in each area. Any one client may have had high ratings in more than one area. Hence the percentages do not total to 100.

Table 4.7

Client Excesses*

	Males (N = 28)		Females (N = 43)	
	N	%	N	%
I. Social Excesses				
1. Socially objectionable behaviors	5	18	7	16
2. Negative family relations	5	18	3	7
3. Negative social attitudes and feelings	8	29	10	23
4. Dependence	5	18	11	26
II. Motivation - Energy				
1. Over, unrealistic striving	-	-	-	-
2. Overly energized	-	-	-	-
3. Lethargic	-	-	-	-
III. Personal Traits (Self-Related)				
1. Self-preoccupied	-	-	2	5
2. Negative self-attitudes	6	21	7	16
3. Overly self-protective, controlled	3	11	6	14
4. Egoistic	4	14	2	5
5. Self-indulgent	-	-	3	7
6. Extreme self-standards (e.g., perfectionism)	4	14	3	7
(Inclinations)				
1. Aggressive - hostile	5	18	-	-
2. Passive - shy	-	-	3	7
3. Idealistic, overly demanding	2	7	6	14
4. Pessimistic	-	-	-	-
5. Undependable	-	-	-	-
6. Emotionally labile, impulsive	3	11	3	7
(Cognitive Tendencies)				
1. Paranoidal	-	-	-	-
2. Preoccupied (ruminative, obsessive)	6	21	5	12
3. Exaggerates	-	-	3	7
4. Misperceives events as threatening	-	-	-	-
5. Autistic	-	-	-	-
(Common Symptoms)				
1. Depressed	-	-	5	12
2. Anxious	-	-	4	9
3. Guilty	-	-	2	5
4. Fearful - panicky	-	-	12	28
5. Hysterical	-	-	-	-
6. Delusional	-	-	-	-
7. Hypochondriacal	-	-	-	-
8. Fanatical	-	-	2	5
9. Escape tendencies	5	18	-	-

*The figures under N are the number of high ratings given by counselors. The percentages represent the relative frequency of high ratings in each area. Any one client may have had high ratings in more than one area. Hence the percentages do not total to 100.

Table 4.8

Client-Counselor Objectives

Decrease	Increase
I. Interpersonal	
Decrease dependence on specific others (e.g., emancipate from family)	Develop social skills & relations
Reduce social fears	Improve relations with family members
Diminish tendencies to manipulate & test people	Enrich relations, meet people, friends
Reduce marital or child problems	Develop more interpersonal confidence
	Develop more trust in others
	Improve dependability & responsibility
II. Education	
	Enable to obtain & complete training
	Help explore educational interests, goals & possibilities
	Help find suitable job training
III. Occupation	
	Develop good working habits & skills
	Help locate work
	Explore, clarify & develop occupational direction
	Help develop realistic vocational goals
	Provide work experiences
	Help develop vocational goals
IV. Personal Change	
A. Changes in Behavioral and Emotional Problems	
Decrease impulsive tendencies	Help develop interests
Reduce specific compulsive living patterns	Establish independent living
	Increase activities
Reduce tendencies for extreme behaviors	Expand leisure time interests & skills
Reduce emotional excesses	Develop self-protective skills
Reduce anxiety, depression, hostility	Learn to follow through on commitments
Reduce excessive use of drugs or alcohol	Learn to deal directly with situations

(continued on next page)

Table 4.8 (continued)

Decrease	Increase
	Improve emotional stability
	Encourage more expression of feeling
	Learn to deal more realistically with problems
	Increase ability to tolerate stressful situations
B. Changes in General Attitudes, Perception and Values	
Reduce need to excel	Increase ability to value self as a person--an entity
Decrease pessimism	Improve self-concept
Decrease suspiciousness	Develop positive attitude
C. Changes in Awareness, Understanding, Knowing	
	Reappraise marital situation
	Improve self-understanding
	Help establish realistic goals
	Gain better understanding of feelings and behavior
	Establish goals
	Explore interests
D. Cognitive Processing (Thinking, Appraising, Perceiving)	
Reduce detrimental preoccupation	Become better organized
Decrease tendencies to overwhelm self	Improve ability to plan and establish goals
Reduce perceptual distortions	Improve decision making ability
Reduce tendencies to exaggerate	
V. Concrete Services--Situational Intervention	
Reduce feelings of overwhelming and frustration via assistance with situational needs	Help client accept & prepare for surgery
Reduce dependence on medication	Help resolve financial problems
	Assist with post-hospital adjustment
	Help obtain information about and obtain benefits
	Work toward stabilizing meds
	Assist in learning basic living skills
	Assist in obtaining housing or improving living situation
	Obtain medical, dental care
	Obtain prostheses

(continued on next page)

Table 4.8 (continued)

Decrease	Increase
	Serve as advocate in problems with agencies
VI. Program and Counseling Specific	
	Improve working relationship in counseling
	Increase investment in program

Objectives given most frequently by counselors were oriented toward changes in clients' personal characteristics. By far the largest number of objectives, 98%, were directed toward inducing some kind of development or improvement--increasing abilities, improving functioning or bettering conditions. Only 13% of the objectives were addressed to decreasing or diminishing negative attributes. This suggests that counselors saw clients' problems as stemming mainly from deficiencies and that they oriented their efforts toward assisting and enabling clients to acquire useful skills, develop latent abilities and improve social functioning and conditions.

Generally, the goals entailed implementing new opportunities and experiences whereby skills and confidence could evolve. They also aimed at lifting constraints and opening new freedom for self-direction. Clearly, relieving symptoms was of secondary importance except in the sense of toning down excesses that patently impeded other types of development.

Outcome Comparisons

With some groups both pre-program and post-program measures were obtained which made "within" comparisons possible. In the case of groups for which both pre- and post-measures were not available, only "between" comparisons could be made. Within comparisons are between measures of functioning prior to a program and the same measures after participation for members of the same group. This is a "longitudinal" approach wherein Ss, in effect, serve as their own controls. Between comparisons are between different groups on pre-program, post-program or both pre- and post-program measures which is a "cross-sectional" approach.

Five groups (actually ten, since sexes were studied separately) were compared with one or both of the above approaches. The groups were: Rejects, Terminates, +30 and -30, Graduates and Comparison Ss.

The measures used in outcome comparisons were:

(1) percentage in-hospital-time for three years pre and one year post;
(2) percentage time employed for one year pre and one year post;
(3) pre- and post-major life areas (MLA) total scores;
(4) pre- and post-PSI, I&P, and SDI fa and uf self-description scores;
(5) counselors' ratings of objectives attainment;
(6) staff ratings of client gains.

The diagram in Figure 4.2 may help clarify the types of comparisons and the groups and measures involved.

The Xs in Figure 4.2 stand for measures obtained for the groups represented. The diagonal lines connect pre- and post-measures available for the same group. In these cases, longitudinal "within" comparisons were made; e.g., the significance of change between a pre- and a post-measure was tested. In addition, for each measure in the same row, the significance of differences between groups was determined. Likewise, the relative changes over groups (interactions) were compared.

Figure 4.2

Types of Comparisons, Groups and Measures

Measures	Groups / Conditions	Grads		Terminates +30		Terminates -30		Rejects		Comparisons	
			Post		Post		Post		Post		Post
1. In-Hospital-Time	Pre	X		X		X		X		X	
			X		X		X		X		X
2. Employment Index	Pre	X		X							
			X		X						X
3. MLA Total Score	Pre	X		X		X		X			
			X		X						X
4. Self-Evaluation SDI fa & uf, PSI, I&P	Pre	X		X		X		X			
			X		X						
5. Objectives Attainment	Pre										
			X		X						
6. Gains Ratings	Pre										
			X		X						

For all groups, pre- and post-measures were available only for in-hospital-time. Only the Graduate and Terminate+30 groups had pre- and post-measures in the first four areas. Cross-sectional comparisons were made between groups with either pre- or post-measures in the same row.

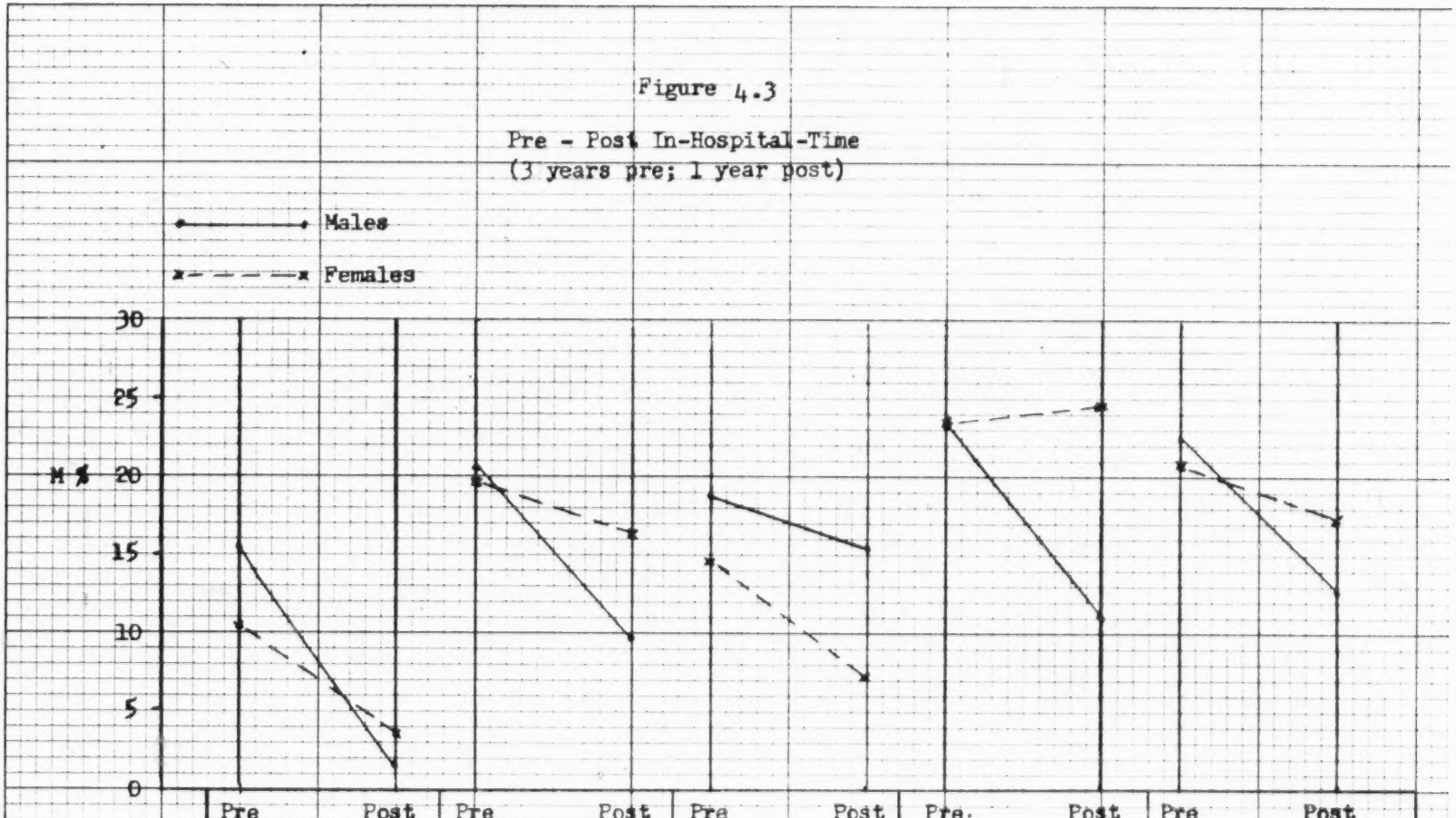
Pre-Post In-Hospital-Time

Figure 4.3 contains mean percentages of 3-year pre and 1-year post in-hospital-time for males and females of all groups shown graphically and numerically.

Comparing differences between pre- and post-means, it may be seen that in-hospital-time decreased from pre- to post-periods for all groups except female Rejects. It may also be noted that this decrease is largest for male Graduates relative to other male groups and the same is true for female Graduates with the exception of Terminates-30. However, summaries of analysis of variance contained in Appendix D show that the Fs for interaction between groups and pre-post-changes were not significant for either sex. This means that since all groups improved as much as they did (except female Rejects), the relative degree of improvement between groups was not sufficiently different to achieve statistical significance.

Figure 4.3

Pre - Post In-Hospital-Time
(3 years pre; 1 year post)



		Grads. Pre	Grads. Post	Term. +30 Pre	Term. +30 Post	Term. -30 Pre	Term. -30 Post	Rejects Pre	Rejects Post	Comparison Pre	Comparison Post
MALES	N	18		12		12		43		32	
	M	15.4	1.7	20.5	9.9	18.9	15.3	23.2	11.1	22.4	12.7
FEMALES	N	29		17		24		28		39	
	M	10.5	3.6	19.8	16.4	14.7	7.1	23.5	24.5	20.9	17.3

Nevertheless, male Graduates spent an average of less than 2% post-program time in the hospital while all other male groups spent 10% or more. Likewise, female Graduates spent 3.6% in-time following program participation while other groups (except Terminates-30) spent over 15% time in the hospital on the average.

Since overall differences between groups were not significant with the percentage in-time measures, frequencies were examined. These consist of the number of Ss from each group who were in or not in the hospital during a one-year period pre-program and the one-year post-program period. Two chi square tests were applied to these data. One involved four-fold contingency tables for each group and tested the significance of changes in the number of Ss who were in or not in the hospital during the pre-period relative to the post-period. The second tested the overall significance of differences between groups in terms of the relative number of Ss in the hospital during the post-period.

Males and females were combined in each comparable group to increase the Ns. Chi square tests of changes were significant at less than the .05 level for all groups except Terminates-30. This finding is consistent with the analysis of variance in which the main effect of pre-post decrease over all groups was significant for both males and females.

The second test of differences between groups in terms of Ss hospitalized during the post-period was significant at less than the .05 level. The major contribution to this chi square was the deviation from expected values in the Graduate group.

To give a picture of the number of Ss from each group who were hospitalized during the pre- and post-periods, frequencies and percentages are given in Table 4.9. These data show that fewer Graduates were hospitalized during the post-period and the difference between the number of pre- and post-hospitalizations was larger for Graduates than other groups. In terms of community residence, 89% male and 83% female Graduates remained in the community for one year without being rehospitalized.

The findings indicate that since all groups improved in terms of pre-post in-hospital-time (except female Rejects), program participation was not a unique determinant. Fewer Graduates returned to the hospital after program participation than did members of other groups for comparable periods, but they also had spent less time in the hospital beforehand. Trends with this measure were consistent with the hypothesis that clients gained from program experiences, but no clear cause and effect relation can be inferred from the statistics.

Pre-Post Employment

The mean percentage time employed pre- and post-program for Graduates and Terminates+30 is shown graphically and numerically in Figure 4.4. Also included is the average time employed for Comparison Ss. Analysis of variance summaries are given in Appendix E. It was possible to obtain post-employment information for some Ss not available for follow-up interviews. Hence the Ns here are larger than in the case of MLA scores.

Table 4.9

Number of Males and Females Hospitalized
During Pre- and Post-Periods

Males		One Year Pre		One Year Post		
N	Group	No.	%	No.	%	% Difference
18	Grads	12	67	2	11	56
12	Term+30	9	75	4	33	42
12	Term-30	10	83	6	50	33
43	Rejects	23	79	13	30	49
32	Comp.	23	72	12	38	34
Females		No.	%	No.	%	% Difference
29	Grads	17	59	5	17	42
17	Term+30	13	76	9	53	23
24	Term-30	15	63	10	42	21
28	Rejects	21	75	14	50	25
39	Comp.	33	85	18	46	39

From Figure 4.4 it may be observed that Graduate and Terminate males were employed about the same proportion of time prior to entering RECOVER. During the year after departure Graduates showed clear improvement while Terminates declined. These overall differences (pre-post employment by groups interaction) were significant at less than the .05 level. In the case of females, Graduates showed a pre-post improvement while Terminates made no gain. Although the difference of 23.5% between post-means of the two groups is relatively large, the interaction F was not significant.

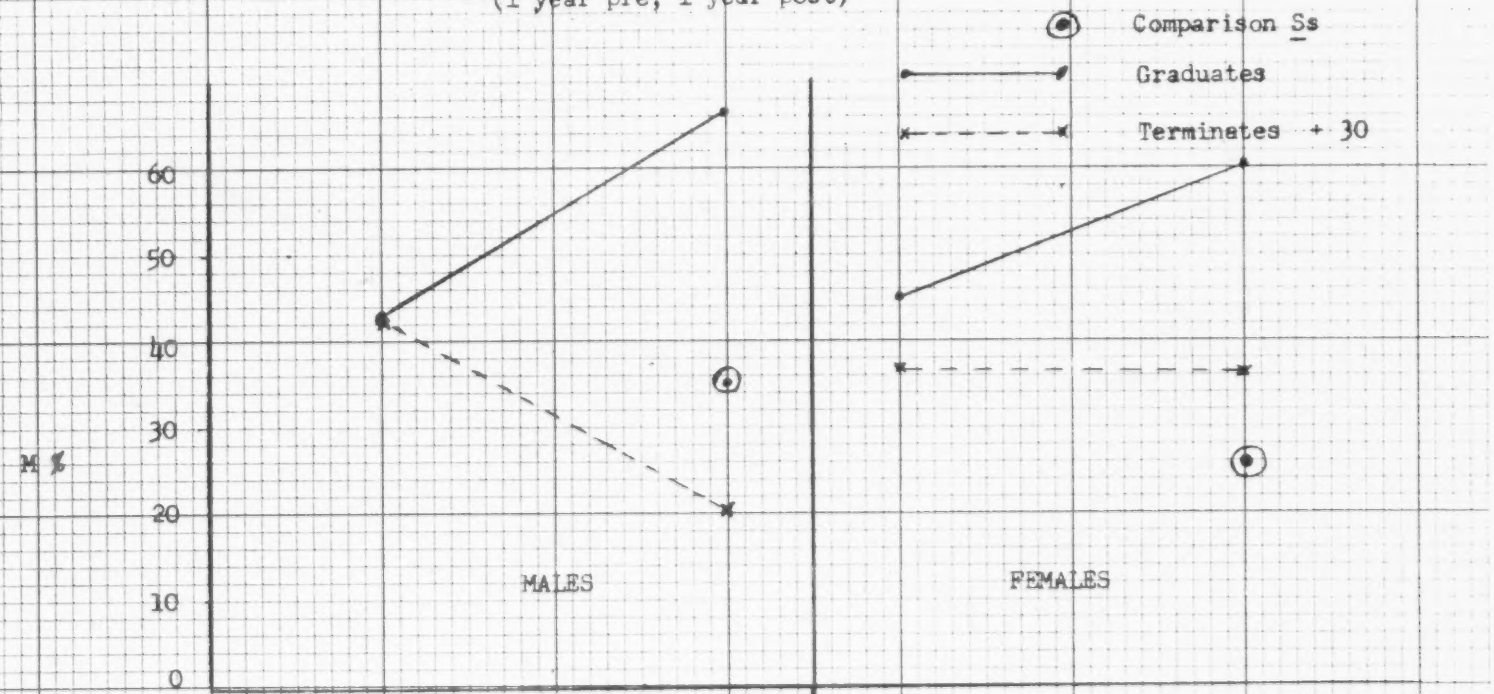
Both male and female Graduates had significantly larger proportions of employed time than Comparison groups while Terminates and Comparison groups did not differ significantly.

The definition of employment poses problems. If it is considered only a remunerated job, then other types of work, mainly homemaking and training, are classed as unemployment. Since jobs, homemaking and training are vocations, or vocation related, we preferred classing time spent in these constructive activities as employment. A breakdown of Ss engaged in the three types of activities, or combinations thereof, at any time during the post-employment year is given in Table 4.10.

In terms of the number of people employed 6 months or more during the one-year post-program period, 72% male and 68% female Graduates met this criterion. In contrast, none of the male and 38% female Terminates and 38% Comparison males and 25% Comparison females were employed 6 months or more. To test the significance of differences between groups, frequencies of males and females from like groups were combined. The chi square value for these data was 20.88 which with 2 degrees of freedom is significant beyond the .001 level.

Figure 4.4

Pre - Post Percentage Time Employed
(1 year pre; 1 year post)



		Males		Females	
Graduates	N	18		25	
	M	43.4	66.3	45.8	60.4
Terminates + 30	N	9		13	
	M	42.7	20.2	37.0	36.9
Comparison	N	32		40	
	M		35.3		26.0

Table 4.10

Types of Employment During Post-Year

	Graduates and Terminates		Comparison Groups	
Females	N	%	N	%
No Job, Education or Homemaking	9	23.7	25	62.5
Job (any duration)	12	31.6	8	20.0
Education	1	2.6	1	2.5
Homemaker	6	15.8	5	12.5
Job and Education	5	13.2	0	--
Job & Homemaker	5	13.2	1	2.5
% Employed (any form)		76.3		37.5
Males				
No Job or Education	3	11.1	12	37.5
Job (any duration)	19	70.4	20	62.5
Education	2	7.4	0	--
Job and Education	3	11.1	0	--
% Employed (any form)		88.9		62.5

Comparisons between pre-post time employed of Graduates and Terminates show that male Graduates made significant gains relative to their own pre-program level and the post-program level of Terminates. Female Graduates, too, showed improvement relative to their former level. They also were superior to Terminates with regard to post-employment. However, these differences were not statistically significant.

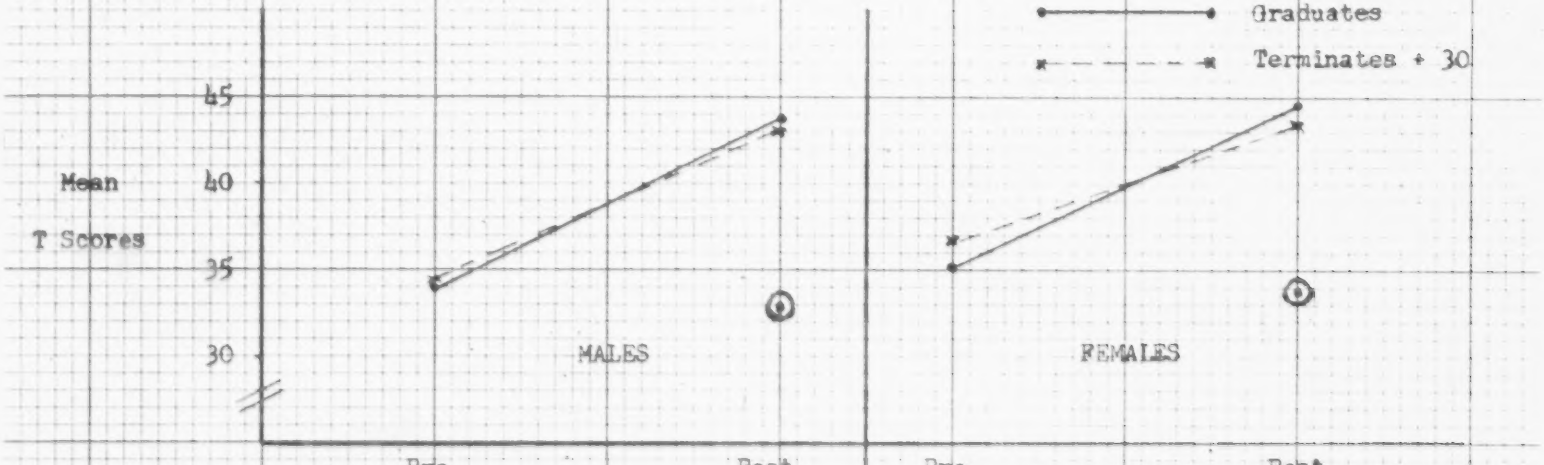
In contrast to Comparison groups, both male and female Graduates were significantly more successful. In this regard it is noteworthy that Comparison Ss actually had an advantage over Graduates. Comparison people left the hospital during 1969 before the recession in Washington was full blown. Graduates in contrast began entering the labor market in 1970 and 1971 when the economy was at its worst. Thus, clients who made full use of the program gave evidence of significant improvement in occupational functioning despite adverse conditions.

Pre-Post Social Adequacy (Major Life Areas Total Scores)

The Major Life Areas (MLA) total scores of both male and female client groups obtained at intake and from the one-year post-program follow-up interview were compared by means of analysis of variance. Comparisons were also made with scores of Comparison groups obtained from follow-up interviews one year after discharge from the state hospital. Figure 4.5 contains the means and graphs for these data. Analyses of variance for males and females are summarized in Appendix F. Attri-

Figure 4.5

Pre - Post Social Adequacy
(Major Life Areas Total Scores)



		Males		Females	
Graduates	N	13		22	
	M	33.9	43.8	35.1	44.7
Terminates + 30	N	5		13	
	M	34.4	43.0	36.9	43.5
Comparison	N	32		39	
	M		32.9		33.9

tion in one-year follow-up contacts meant MLA information could not be obtained for 8 Graduate and 4 Terminate females and for 6 Graduate and 8 Terminate males.

A slight difference may be noted between trends of Graduates and Terminates. Both male and female Terminates' scores were a little higher than Graduates initially but upon follow-up were a little lower; these differences, though, were not significant. Improvement between pre- and post-scores for both male and female groups was significant at less than the .01 level.

MLA scores are expressed in T score units based on distributions of scores from "normal" samples. T scores are standard scores which, by convention, have means of 50 and standard deviations of 10. Thus, it can be seen from Figure 4.5 that the pre-scores of Graduates and Terminates were about one-and-a-half standard deviations below the mean of "normals" (50). At follow-up, the scores of both groups had increased about one standard deviation and were only five to six units below the general average.

MLA scores of Comparison groups were contrasted with post-scores of Graduates and Terminates and tested for significance by analysis of variance. Both male and female Comparison group means were significantly below those of Graduates and Terminates at less than the .001 level. However, Comparison group means were not significantly different from the pre-program scores of client groups.

To the extent the MLA total scores measure general social adequacy, the findings show that social functioning of both client groups improved over their pre-program level to a significant degree. The Comparison groups, in contrast, one year after discharge were functioning at about the level of clients prior to RECOVER. Both longitudinal and cross-sectional comparisons suggest that the general social adequacy of program participants was enhanced.

Effects of Follow-Up Attrition

In the case of outcome measures based on follow-up information--post-employment index and post-MLA scores--attrition was much larger than anticipated. In order to assess implications of this loss of Ss on findings, three outcome measures which were available from sources other than follow-up interviews were compared between groups that did receive follow-up interviews and those that did not. The measures were: post in-hospital-time, objectives attainment and gains ratings.

None of the Graduate groups, followed or not, differed significantly on any of these three measures. Among Terminates one variable was significantly different between Ss interviewed and not. Follow-up Terminate females had significantly more post in-hospital-time on the average than those not interviewed--20% versus 4.5%. With males a significant difference also was found with this variable but in the opposite direction. Follow-up Ss had an average of 0.2% in-time in contrast to 16.9% for those not interviewed. Means of the other two variables were not significantly different between groups.

These findings suggest that the employment and MLA comparisons may not have been differentially biased due to attrition. That is, there is no consistent evidence that post-program functioning of Ss who could not be contacted was either better or worse than that of those who were interviewed.

Pre-Post Self-Description

As mentioned, we were interested mainly in self-descriptive questionnaires that reflect how much clients emphasize or de-emphasize certain characteristics. We were not interested in attempting to measure hypothetical personality traits.

Hypotheses regarding changes in questionnaire responses were straightforward and simple. If clients gained from the program, we assumed they would become less defensive if that was how they started or less self-derisive and complaining if that was their tendency at the outset. It was also assumed that with experience in setting objectives and pursuing them, their planning abilities should improve. To test these hypotheses, pre- and post-scores from three instruments were analyzed: the SDI, PSI and I&P.

Despite a conscientious staff, efforts were disappointing with regard to post-testing. Twenty-nine out of 48 Graduates (60%) completed pre- and post-testing while only 6 of 29 (20%) Terminates did so. With more than 50% attrition, all told, and small Ns to begin with, findings at best are only suggestive. Appendix G contains means and variances of pre- and post-testing with the SDI, PSI and I&P. Significance of differences were determined by t tests for correlated measures.

Interests and Plans (I&P) and PSI scores did not change significantly from pre- to post-testing. The same was true with the SDI fa and uf scores. However, we expected fa to decrease and uf to increase for guarded Ss and the opposite to occur for those who reported low assets and high liabilities--if such were the case, the opposite trends should tend to cancel each other and decrease the average differences between pre- and post-measures.

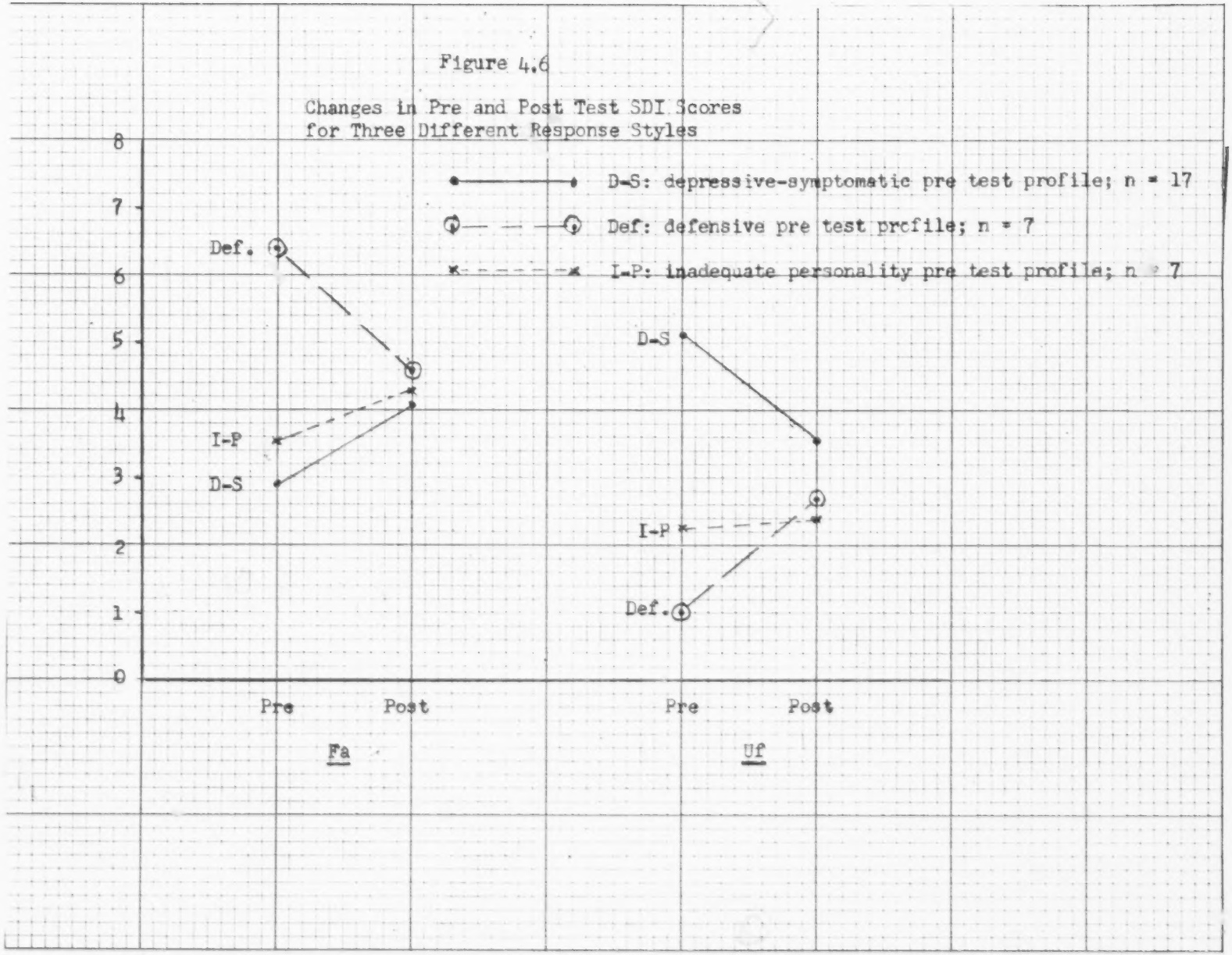
To assess such possible differential changes in SDI scores, Ss were grouped according to response patterns obtained on the SDI at pre-testing (the patterns illustrated in Figure 4.1). From the combined sample of 35, 17 had "depressive-symptomatic," 7 "defensive," and 7 "inadequate personality" patterns. The remaining 4 Ss had other type patterns and Ns were too small to include them.

If the program had benefitted Ss, it was hypothesized the fa scores for the first group would increase and uf scores decrease. For "defensive" Ss the opposite trends were expected. With "inadequate personality" patterns (low on both fa and uf) we expected fa to increase and uf to gain some.

A plot of the means for the three groups thus classified in terms of pre-response patterns is shown in Figure 4.6. It may be seen that expected trends were what occurred. Analysis of variance for fa scores

Figure 4.6

Changes in Pre and Post Test SDI Scores
for Three Different Response Styles



showed a significant interaction between pre-post testing and groups with different intake patterns (interaction $F = 11.24$; $p < .001$; $df = 2/28$). With uf scores the interaction between pre-post testing and groups was also significant ($F = 6.83$; $p < .01$; $df = 2/28$). Thus, the overall changes (differences between differences) among the three groups for both scores were significant despite the very small Ns.

The implication of this finding is that Ss who were initially self-derisive were less so at post-testing; defensive Ss became less guarded and Ss who stressed their lack of assets at the outset felt somewhat more competent when they left.

One problem with this interpretation is that observed changes could be attributed to "regression toward the mean." That is, high scores tend to decrease and low scores to increase on retesting. Whether observed changes were greater than could be expected on the basis of regression toward the mean (and hence attributable to program effects) would have to be assessed by regression analyses requiring far larger samples or by comparisons with suitable control groups. Unfortunately neither refinement is possible at this point. Findings are consistent with the assumption that clients' self-concepts tended to improve in the sense of becoming more realistic or less derisive. But due to small Ns, and lack of controls for regression toward the mean, this assumption is quite tentative.

Additional Outcome Measures and Correlations

Objectives Attainment

Potential uses of the "objectives approach" and an overview of clients' needs inferred from objectives developed by counselors were discussed. Another application consists of estimating outcome on the basis of counselors' ratings of objectives attainment.

Frequency distributions of attainment ratings averaged over objectives for each client are shown in Table 4.11.

Table 4.11

Distributions of Objectives Attainment Ratings

Attainment	Graduates		Terminates+30		Total	%
	Male	Female	Male	Female		
Full 5	1					
Good 4-4.9	4	10			15	21
Moderate 3-3.9	9	12	3	5	29	40
Very Little 2-2.9	3	6	6	5	20	28
No 1-1.9			2	6	8	11
M	3.2	3.1	2.1	2.0		
N	17	28	11	16	72	
σ^2	.65	.57	.49	.67		

From the preceding table, it may be noted that ratings of attainment are higher for Graduates than Terminates as would be expected since Terminates, by definition, quit prior to accomplishing all they might.

Eighty percent of the male and female Graduates were seen as having achieved objectives at a moderate or better level. In contrast, 70% of the Terminates were rated as having very little or no attainment. With all Ss combined, 61% had moderate or better attainment while 39% were judged to have very little or none.

Gains Ratings

A second outcome measure based on observer judgments is the gains ratings. Objectives attainment ratings were made about the time clients left the program and were based on counselors' experiences with them during program participation. Gains ratings were different in that all staff acquainted with clients made them. Furthermore, gains ratings were obtained after the cut-off date when most of the Graduates and Terminates had been out of the program for a year or more. Thus, raters had much feedback information derived from various sources. Gains ratings were intended to be global estimates of client benefits both from the standpoint of subjective, personal changes and overt, behavioral improvements. These in turn were estimated by at least three independent judges for each client.

Table 4.12 contains frequency distributions of gains ratings.

Table 4.12

Distributions of Gains Ratings

Gain	Graduates		Terminates+30			
	Male	Female	Male	Female	Total	%
Very Good 5						
Good 4-4.9	3	5			8	10
Moderate 3-3.9	7	14	2	2	25	32
Very Little 2-2.9	8	8	6	7	29	37
None (or Worse) 1-1.9	1	4	5	7	17	22
M	3.2	3.2	2.0	2.2		
N	19	31	13	16	79	
σ^2	.75	.73	.50	.47		

Again, ratings for Graduates tended to be higher than those of Terminates. The gains ratings showed 58% as having made moderate or better gains. Terminates fared less favorably in that gains ratings for 86% of them lay in the very litt[l] , none or worse regions. Collectively, 42% of all Ss were rated moderate or better in gains and 58% were seen as having advanced very little or none.

Outcome and Program Participation Correlations

Outcome measures were derived from four sources: hospital records, client interviews, changes in client self-description and staff judgments. Interrelations among three of these different types of outcome indices and ratings of client program participation are shown in Table 4.13.

Table 4.13

Correlational Matrix for Outcome and Program Participation Measures

	Post IHT	Post EI	Post MLA Total	OA	Gains
PrP[a]	-.29*(77)	.26*(65)	.25*(54)	.39*(72)	.70*(79)
Post IHT		-.37*(62)	-.32*(54)	-.23*(70)	-.34*(76)
Post EI			.27*(54)	.43*(60)	.38*(65)
Post MLA				.11(50)	.32*(54)
OA					.56*(71)

[a]Abbreviations mean the following: PrP = Program Participation ratings; IHT = In-Hospital-Time; EI = Employment Index; MLA = Major Life Areas; OA = Objectives Attainment; Gains = Gains Ratings.
*Significant at .05 level or less; Ns in parentheses.

As with other correlations, all Terminates and Graduates were combined. Measures based on client responses to self-descriptive questionnaires were not included due to attrition and the fact that questionable difference scores would be needed to reflect change.

It is reassuring to find that all major outcome variables were significantly related (except MLA with OA) and in appropriate directions. All were obtained from different methods and/or sources and were intended to measure different variables. But, all of the outcome variables are also logically related to a general factor that we feel reflects competence. The above matrix empirically supports the assumption of such a general factor. For example, although relations were not strong, they are consistent with assumptions that the more competently a client functioned, the less time he would spend in the hospital, the more time he would be employed, the better he would achieve objectives, the more he would be likely to make gains and the better his general social

functioning.

An additional point of interest is the fact that all outcome variables were significantly correlated with program participation ratings (PrP). Although the correlations with PrP are not particularly large (except for "gains"), their consistency over the variety of methods and variables supports the assumption of a general positive program effect. That is, the more a client availed himself of program opportunities, the more likely a favorable outcome. Correlational analyses, though, cannot prove cause and effect relations. Thus, the obtained correlations cannot settle issues such as whether better use of the program caused good outcome or whether better clients made better use of the program and outcome would have been good anyway.

Correlations Between Background, Intake, Participation and Outcome Measures

Correlations between main background and self-description measures (input), program participation (process) and outcome (output) are given in Table 4.14. A glance shows that relations among these measures, which focused on different temporal periods, are sparse indeed.

Only a few relations warrant comment. Surprisingly, the very accurate measure of chronicity (percentage in-hospital-time over three years) correlated significantly only with post in-hospital-time. The only other significant correlations between major background and outcome measures were P-R with post-employment and objectives attainment (the more process the less of these). None of the background indices were related to program participation (PrP).

Estimated verbal IQ was not related to PrP or any outcome variables. Likewise, self-description questionnaire scores were unrelated to PrP and outcome variables with one notable exception: five of the MMPI pathology scales correlated significantly and inversely with program participation and objectives attainment (but not with measures of actual post-program functioning).

Correlations with MMPI scales imply that clients with high pathology scores may have behaved more pathologically and hence participated less and achieved less. But, if their behavior were in fact more pathological than that of low scorers, theoretically they should have functioned more poorly in other outcome areas as well. This expectation was not substantiated by the correlational findings. However, it is noteworthy that in-hospital-time, the most reliable index of pathology, also failed to predict outcome in areas of functioning other than rehospitalization.

The answer may lie in the possibility that prediction from background variables or questionnaire scores of such complex, interactive phenomena as a psychiatrically disabled person's subsequent adaption to the multiple

Table 4.14

Correlations Between Background, Intake, Participation and Outcome Measures

		Outcome Measures				
	PrP[b]	Post IHT	Post EI	Post MLA	OA	Gains[a]
Background						
Pre IHT	.11	.31*	-.18	-.06	-.17	-.05
Pre EI	0	-.13	.18	-.13	.15	.06
P-R	.02	.08	-.37*	-.16	-.20*	-.18
Pre MLA	-.06	-.11	.19	.16	.05	.11
Verbal IQ						
Shipley	.02	-.12	.16	-.24	.03	
Self-Description						
SDI: Fa	.14	.12	-.02	.40*	-.08	
Uf	-.09	-.08	.05	-.17	.06	
MMPI: K	.18	.16	-.04	.27	.13	
D	-.16	-.09	-.11	-.25	-.17	
Hy	-.05	-.06	-.09	-.12	-.18	
Pd	-.28*	-.10	-.12	-.10	-.40*	
Pa	-.32*	.12	-.24	-.12	-.37*	
Pt	-.26*	-.02	-.20	-.22	-.41*	
Sc	-.26*	.02	-.18	-.12	-.44*	
Si	-.31*	.04	-.11	-.31*	-.35*	
De	.30*	.14	-.01	.11	.12	
Un	-.15	-.01	-.12	-.26	-.33*	

[a]Gains ratings were not available for computer analysis; they, therefore, were only correlated with the primary background variables.
[b]PrP = Program Participation, IHT = In-Hospital-Time, EI = Employment Index, MLA = Major Life Areas total score, OA = Objectives Attainment.
*Significant at .05 level or less.

and often chance vicissitudes of life is more will-o'-the-wisp than otherwise.*

Summary of Outcome Findings

Five groups were compared on one or more of six outcome measures. These groups were also compared in terms of background and self-description variables obtained at intake. The several groups compared were similar with regard to the majority of background and self-descriptive scores. A primary exception was that Graduates on the average spent less time in the hospital during the pre-program period than members of other groups.

Male and female Graduates showed the greatest improvement among all groups regarding the degree of change in pre-post time in the hospital. But since in-time of other groups also decreased, the relative differences were not statistically significant. Nevertheless, in absolute terms, the amount of time Graduates spent in the hospital during the post-year was about five times less than that of other groups. In addition, 89% of the male and 83% of the female Graduates were not rehospitalized during the post-program year which is slightly better than the best attainment of other programs reviewed. These findings are consistent with the assumption that program participation benefitted clients but reduction in recidivism could not uniquely be attributed to the program.

In the case of pre- and post-employment comparisons, Graduate males were employed a significantly greater proportion of time during the post-program year than the year before (or over a three-year span before). This change was significantly different from Terminates whose time employed decreased. Female Graduates also improved over their pre-program record while Terminates did not, but the difference was not significant. Both male and female Graduates (but not Terminates) were employed a significantly greater proportion of the post-year than were either of the Comparison groups.

With a criterion of full-time employment for six months or more during the post-period, Graduate males and females were significantly superior to both Terminate and Comparison groups. Furthermore, where 72% male and 68% female Graduates met this criterion, the rate of employment is also comparable to the highest attained in programs reviewed with a seven-month to one-year follow-up period.

---

*Literally, hundreds of studies support this point. A fine illustration because of its good quality is that of Lorei (1967). Questionnaires completed by patients, staff ratings and ratings by relatives were obtained at discharge for 215 male Ss. All told, the questionnaires and ratings consisted of 258 items. Six Varimax factors were extracted and these were correlated with two outcome measures: (a) days in community over one-year post-discharges, and (b) whether or not S was employed full time for at least six months. Five significant correlations between the predictor factor scores and the two outcome variables were obtained. Their magnitudes were: -.16, -.17, .33, .14 and .19 (the small rs being significant because of the large number of Ss). Correlations of this size, like those found in the RECOVER evaluation, hardly constitute prediction.

Turning next to indices of pre- and post-program social adequacy (MLA total scores), both male and female Graduates and Terminates+30 showed significant gains. Graduates improved slightly more than Terminates but not significantly so. Compared to their pre-level of functioning, all client groups improved to a significant degree. Clients' average scores for the pre-period were about the same as those of Comparison Ss one year after departure from the hospital. Furthermore, the post-program scores for all client groups were significantly higher than those of the Comparison groups.

In terms of social adequacy, groups that participated in the program over 30 days improved both relative to their former level of functioning and in contrast to Comparison Ss.

Although there was an unfortunate amount of attrition in employment and MLA follow-up information, attrition was particularly severe in the case of post self-description scores. The 35 Ss from whom both pre- and post-data were obtained were combined without regard to sex or program status. For these people, there were no significant differences between average pre- and post-I&P, PSI and SDI fa and uf scores. However, when Ss were classified in terms of their intake SDI scores as defensive, depressive-symptomatic or inadequate personality types, it was found that significant changes had occurred. The defensive became less so and the depressive-symptomatic showed an improved self-concept as did those with an inadequate profile. These findings, while not in any sense conclusive, suggest that program participation may have had a salutary effect on self-attitudes.

To assess staff impressions of client accomplishments, counselors' ratings of objectives attainment and ratings of clients' gains were compared between Graduates and Terminates+30.

Eighty percent male and female Graduates were judged to have attained their objectives to a moderate or better degree. Only 30% of the Terminates in contrast were seen as having achieved objectives at that level.

In terms of the gains ratings, averaged over at least three raters per client, 58% of the Graduates were seen as making moderate or better gains, while only 14% of the Terminates were judged to have fared that well.

All outcome measures and ratings of program participation correlated significantly with each other (excepting MLA with objectives attainment). Consistencies within this matrix suggest a general competence factor: Clients who participated more effectively also functioned better in terms of time in the community, employment and social adequacy and, in addition, were judged to have made better gains.

Correlations between background, self-descriptive, program participation and outcome measures were with few exceptions not significant or they failed to suggest consistent trends--a finding which itself is quite consistent with results of numerous other studies.

The outcome findings considered collectively point consistently in the direction of improved functioning for RECOVER Graduates. Seventy-two percent of the Graduates showed improvement in three or more of the six outcome areas studied (including changes in SDI profiles). This may be contrasted with Terminates where only 23% improved on three or more indices. In every area Graduates' average post-measures had improved over like indices of their own pre-program functioning. Furthermore, Graduates' mean scores were higher than those of all other groups with which they were compared. In several instances the differences were not statistically significant but the trends were always in the improved direction. In no instance did a group that was expected to function less well than Graduates excel. These consistencies are all the more impressive in light of the small samples which are subject to greater sampling fluctuations and hence are less reliable than larger samples. The probability of obtaining 100% consistency in the direction of trends over all comparisons, both longitudinal and cross-sectional, by chance would be quite remote.

Cost and Potential Savings

The SRS grant for RECOVER was $72,000 a year; the State contributed approximately $23,000 the first year and $19,000 during the ten months it was applicant agency in the second year. All of the applicant share and a little over 10% of the federal share supported the research component. With current expenses, an aftercare and rehabilitation program like RECOVER would cost about $80,000 a year without research staff.

Since the program began from scratch, it took time to develop referral sources, to relocate in the community and become well established. Thus it was not until the third year that demand required the development of a more efficient system for delivering services. Now the program is operating at full capacity and we estimate it can graduate at least 70 clients a year.

At the cut-off date 50 clients had graduated and $195,000 had been spent in providing services. Each graduate, therefore, was produced at a cost of $3,900.

On the average, male and female Graduates spent 47 days a year in the hospital before the program, which at $20* a day for three years would have amounted to $2,820 per person. Thus, the cost of the program was $1,080 more than continued hospitalization at the pre-program level. However, far more than this enters into the picture. For one thing, many more than the 50 Graduates were served by the program; up to the cut-off date, 66 Terminates (+30 and -30) received services for anywhere from a week or two to several months. How much they benefitted is very difficult to estimate. From staff gains ratings, only 14% of the Terminates+30 were judged to have benefitted. Nevertheless, a number of Terminates began reapplying during the third year which may mean their first experience with RECOVER kindled a spark of hope. It would not in any event be sound to consider the efforts devoted to these people a total waste.

*This figure is the latest cost estimate provided by the hospital Business Manager.

Furthermore, from a purely financial standpoint it can be shown that in terms of relative improvement rates of Graduates with regard to time in the hospital and employment, the program could quite likely more than pay for itself.

Taking account of the spontaneous decline in hospital in-time of all groups, the greater decrease of Graduates amounted to a saving of 15 days per year on the average. With 70 Graduates a year and like reductions in rehospitalization, $21,000 per year would be saved with hospital care costing $20 a day.

In addition, 51% of the Graduates moved from being dependent on Public Assistance to self-sufficiency. If the same proportion of 70 clients did likewise, this would mean a saving of $62,640 a year in disability grants paid by Public Assistance at the current rate of $145 a month.

There is also the prospect of a gain from income and other taxes paid by the people who moved from unemployed to employed status. Assuming they earned only minimum wages of $1.60 per hour and worked 50 weeks a year, their salaries would be $3,200 which the IRS estimates would require payment of $173 income tax. At least half that amount also would go for state and local taxes. Altogether the 36 of 70 clients expected to become employed would pay $9,324 a year in taxes.

When the savings in hospitalization and Public Assistance are added to the gains in taxes, the total amount is $92,964 per year or $12,964 more than estimated costs of operating a program like RECOVER. Furthermore, if such a program endured over time and with follow-up services enabled Graduates to sustain their gains and continue developing, the savings would be accumulative.

Clients' Evaluations of Program Benefits

In concluding the program evaluation it is fitting to look briefly at clients' impressions. Every three months all clients in the program were asked to complete the RECOVER Questionnaire, which afforded an opportunity for consumers to evaluate the program anonymously. This procedure has the drawback that the same client may have completed the questionnaire more than once. Some also completed it who had only participated a short time but we tried to avoid giving questionnaires to beginners.

The questionnaire contains eight sections, six of which require written comments and two a series of ratings; only the ratings will be reported.

The first 8 ratings were made on a 5-point scale with anchors ranging from 1. Very Helpful to 5. Very Harmful. Ratings were made in response to the question "How helpful have the following aspects of the program been to you?"

The second set of ratings cover 7 different types of personal benefits to be rated on a 5-point scale with anchors ranging from 1. Very

Much to 5. Very Little. The question to be rated was "How much has the RECOVER Program helped you in the following areas?"

Since ratings were anonymous, clients were not grouped by sex or program status. The mean ratings for each type of content are shown in Table 4.15.

Table 4.15

Client Ratings of Program Benefits
(Ns Ranged from 134 to 143)

A. How helpful have the following aspects of the program been for you?

	Mean	Rank
1. Education	2.02	5.5
2. Leisure Time	2.07	7
3. Job-Sampling	1.93	3.5
4. Counseling	1.36	1
5. Contact with other clients	1.80	2
6. Small group meetings	1.93	3.5
7. Large group meetings	2.02	5.5
8. Medication	2.33	8

B. How much has the RECOVER Program helped you in the following areas?

	Mean	Rank
1. Understanding myself	2.22	2
2. Planning for the future	2.32	3
3. Enjoying other people	2.17	1
4. Knowing how to carry out plans	2.52	5
5. Feeling more confident	2.33	4
6. Knowing how to enjoy leisure time	2.98	7
7. Knowing more about the resources in Tacoma	2.70	6

From the preceding table it may be seen that average ratings in all areas tended toward the favorable ends of the scales and did not provide much differentiation between content. Likewise, variances were small and quite similar over all areas and thus were not given. Nevertheless, from ranks of the means it may be inferred that clients considered counseling the most helpful service. The experiences judged next most helpful were contacts with other clients, job-sampling and small group meetings. Relative to other areas, leisure time activities and medication were seen as less helpful and were rated for the most part in the vicinity of slightly helpful.

Regarding personal benefits, clients indicated they had benefitted most in terms of enjoying other people and understanding themselves. The least was gained in learning how to enjoy leisure time and knowing about community resources. The lowest rank for leisure time was consistent with our own impressions that leisure time was consistent with our own impressions that leisure time utilization was not only a serious problem for clients but also one of the most difficult areas to improve.

5. DISCUSSION AND CONCLUSIONS

R&D programs are for putting ideas into action and learning from the experience. We feel that considerable was learned during our three years of concentrated focus on the problems and challenges of aftercare and rehabilitation for psychiatrically disabled people.

With regard to the people themselves and their problems, our experiences have given us added confidence in the position of many authors who hold that serious human maladaption is usually associated with an inability to deal effectively with important aspects of oneself and one's environment (Guilford, 1961, 1966; Herzberg, 1966; Rogers, 1961; Wallace, 1967; White, 1965; Woodworth, 1958). This, however, is not seen as disclaiming the role of organic factors such as a genetic propensity in schizophrenia, nor the contribution of cognitive processes nor the importance of human relations and feelings. Impairment in any such way would only compound problems with effective functioning and feelings of competence. The impairments of our clients were multiple, deeply rooted and interdependent and no two people had the same configuration of problems. Thus we remain convinced that there are no across-the-board methods or techniques that are best for resolving the problems of all individuals. Such viewpoints and convictions are hardly new hieing back in many ways to the philosophy of nineteenth century moral therapy (Bockoven, 1956).

Though often alluded to, the application of comprehensive approaches to comprehensive problems has seriously lagged. If RECOVER is unique in any way it is because the program did not embrace some packaged technique but rather sought ways to achieve a functional comprehensiveress.

One program that helped us conceptualize organizational approaches was the Rehabilitation Service Teams (RST) of Ohio (Hutchison, 1971). RST is a system of teams which provide diversified and flexible services for the physically disabled. The teams approach the needs of clients within the context of available community resources. Each team is small and organized horizontally to draw on the ideas and talents of all staff. Another approach that inspired us and many others is that at Fort Logan in Denver. The five teams at Fort Logan, although relatively large with 30 or more staff, serve nearly two million people (Kraft, Binner & Dickey, 1968). Their record for avoiding institutionalization while providing comprehensive care for mental patients is in all probability one of the finest in the nation. One unique feature of these teams is their flexible use of paraprofessional mental health workers. These people serve in many capacities but are especially effective because of their mobility--their ability to go to the patients and assist them in obtaining benefits and services in their communities.

Organization of the team and roles of staff which were discussed in Capter 2 reflect in detail how ideas gained from programs such as the preceding were incorporated into RECOVER. The special team approach and milieu combined with paraprofessional Expediters who reach out to patients and assure effective use of pertinent community resources is the essence of RECOVER. The team and community resources make possible a wide range of opportunities for action-type experiences in which clients learn by doing. Clients who are often very resistive people have little to resist.

They are not forced to do anything. Instead, opportunities for experiences relevant to their avowed needs are made available. If they resist, that is their choice but it gains no reinforcement. Thus, it is not surprising to find that countermotives tend to diminish.

That clients benefitted from the approach may be inferred from the six outcome variables studied. The fact that Graduates on the average had less rehospitalization and more employment than other groups; that their social functioning and possibly their self-concepts improved; and that the majority attained objectives to at least a moderate degree and over half were judged to have made gains, all attest to the likelihood that they profitted from program participation. But there is the cogent question raised by Criswell (1968)--how permanent is their rehabilitation? From studies by Criswell and others (Davis, Dinitz & Pasamanick, 1972) we would predict that for many the improved functioning is likely not permanent. That is, if at times of mounting stress they have nothing to fall back on but themselves, non-understanding relatives or conventional agencies, their "rehabilitation" probably will not last.

Like "curred," "rehabilitated" is a misnomer in our view. We are confident RECOVER does as much for clients as is possible with its resources. But we are just as confident that we cannot take people with years of detrimental thinking, emotional excesses, regressive living, little or no confidence and multiple social disadvantages (including a rejecting society) and within a four to nine months span rejuvenate them to a permanent state of self-sufficient normalcy. The clients are fragile people in many ways and even if a great leap forward were to occur, considerable fragility would remain. Moreover, from a developmental standpoint, they are no longer children who learn with great rapidity. Their learning is slow and especially so because so much must be unlearned.

The permanence of rehabilitation, we feel, is a function of the permanence of effective programs. No one learns to play concert piano in a year and likewise no one learns to live a competent life in even less time. The question then might better be, how can aftercare and rehabilitation programs become more permanent?

Enduring programs are few and scattered. Furthermore, there are no established standards for what constitutes quality aftercare. Thus, most mental health centers and state, federal and county mental hospitals will report on questionnaires that they provide aftercare. But usually this consists of little more than a brief check on medication, occasionally some group therapy, a referral to Public Assistance or Vocational Rehabilitation or a prescription if the ex-patient has the initiative to follow through (Wahler, 1972).

RECOVER faced the problem of survival beyond the federal grant and discovered there is a way. Three ingredients are necessary: (1) a lively program with the community's respect; (2) a progressive mental health center interested in care for ex-mental patients as well as the typical outpatient clientele; (3) the state and local machinery for obtaining aid for the disabled through any of the several pertinent Social Security Act Titles (e.g., 19, 16, 14).

Administration of federal grants to states through Social Security Acts for various needs or disabilities varies according to the type of problem and related contractual arrangements. Where so-called mental disabilities are concerned, at least four parties are usually involved in the contractual arrangements; they are representatives of the federal, state and county or municipal governments and mental health centers. Details of responsibilities, administration, payment procedures, fees and descriptions of services vary among the states. Not all states have developed contracts with branches of the federal or local governments for all Social Security Titles. In addition, not all local governments have established duly appointed mental health bodies, etc. Furthermore, there is a matter of matching money. For example, a mental health center must match payment of Title 19 monies one to one and Title 16 monies one to three. Whether matching money comes from local or state funds is usually determined at the State level. But generally it is possible to apply a major portion of non-federal income as matching money for a gain of anywhere from one to one to three to one.

Where necessary state or local arrangements have not been developed, considerable spade work may be required to establish the necessary agreements and mechanisms. Nevertheless the potential exists for developing aftercare and rehabilitation teams in conjunction with every mental health center in the nation of any size. Once necessary arrangements are established, these teams can support themselves to a large extent from Social Security payments for services to the disabled, since clientele of such programs, with few exceptions, qualify as financially dependent, disabled persons.

An additional important source of support for clients not fully qualified under Social Security comes from state-federal rehabilitation programs. State rehabilitation bureaus or divisions, aside from their vocational counseling, evaluational services and special financial aid programs are primarily contracting agencies. That is, they contract with other agencies for necessary medical, psychiatric, training and supportive services. Thus, as is the case with RECOVER, agreements can be developed with the state agency to pay partial or package case costs for eligible clients. In the case of a program not joined with a mental health center, this can be a major source of income as it has been with another program, COVE, that was able to survive after termination of its federal grant.

Since RECOVER's continuation as a service program is reasonably assured, it is of interest to look briefly at what the staff decided to do with all the measuring and recording apparatus of the research component. Like most people, staff hate paper work. Not surprisingly, they wanted to reduce it to the barest essentials. Nevertheless, they voted to retain five self-administering instruments and one procedure considered clinically useful.

The Background Information Questionnaire was retained since it has three advantages: (a) It is completed by applicants and saves interview time; (b) It contains practical background information that nearly all human service workers find useful; and (c) It obtains and records information in a systematic manner. Staff voted to retain the Shipley-Hartford

as a brief measure of verbal functioning. They also kept the SDI, PSI and I&P. The first two provide useful clues as to how applicants are presenting themselves and the I&P is valuable as an aid in helping clients develop plans. Staff also voted to retain the objectives approach. Counselors felt this helped focus their own conception of work with clients and served as a helpful device in negotiating contracts with them. They also felt it was advantageous to have a record of objectives attainment should a client wish to re-enter the program later. The coordinator, who will remain as program director, felt the accumulating information could be analyzed biannually and thus help in monitoring the program.

In conclusion, RECOVER developed a team approach to providing a broad spectrum of individually patterned and coordinated services entailing extensive use of existing community resources. Among other things, it demonstrated how effectively professionals and trained paraprofessionals (Expediters) could complement each other. Organization of the team and its modus operandi made full use of all staff expertise and with periodic brainstorms implemented its continued development. Not only were staff involved but they also, as Ann stressed in her report of RECOVER experiences, gave clients a feeling of belonging to a big family. The staff see persistence with patience, involvement and availability, along with personal guidance and counseling and providing relevant, timely, action-type opportunities as the key ingredients of developmental aftercare. The focus was the person. It was not a predetermined goal such as vocational training and employment. The person's stage of development (or regression), his values and needs, determined goals. If a client was not ready for competitive employment that, then, was not a goal.

Equally important, with the support of a progressive mental health center, and payments from Social Security and the Division of Vocational Rehabilitation, RECOVER can look forward to a long life. This means the dropouts can try again and the Graduates who begin to topple will have a net. With time and needed help, it is truly remarkable how the human spirit can be resurrected.

REFERENCES

*Bartholow, George W. and Tunakan, Bulent. The role of the community mental health center in the rehabilitation of the long-hospitalized psychiatric patient. Current Psychiatric Therapies, 1967, 5, 216-220.

Beard, John H., Schmidt, James R., and Smith, Mary M. The use of transitional employment in the rehabilitation of the psychiatric patient. Journal of Nervous and Mental Diseases, 1963, 136, 507-514.

Becker, W. C. A genetic approach to the interpretation and evaluation of the process-reactive distinction in schizophrenia. Journal of Abnormal and Social Psychology, 1956, 53, 229-236.

*Bennett, William I. Students, patients share halfway house. Rehabilitation Record, 1964, 5, 21-25.

*Berkowitz, Louis, and Lurie, Abraham. Socialization as a rehabilitation process. Community Mental Health Journal, 1966, 2, 55-60.

Bloom, B. L. Community mental health statistical programs of the future. In Chevy Chase: National Institute of Mental Health Statistics, Series D, No. 1, 1970, 1-6.

Bockoven, J. S. Moral treatment in American psychiatry. Journal of Nervous and Mental Disorders, 1956, 124, 167-194.

*Brodsky, C. M., Fischer, A., and Weinstein, M. R. Modern treatment of psychosis: New tasks for social therapies. Social Work, 1964, 9, 71-78.

*Brooks, G. W. Motivation for work and psychiatric rehabilitation. Diseases of the Nervous System, Monograph supplement, 1961 (April), 22, 129-132.

*Buri, Mason, Gardner, R. Vance, and Matthews, Carol J. Spinning straw into gold. Mental Hygiene, 1972 (Spring), 39-42.

Campbell, Donald T., and Stanley, Julian C. Experimental and Quasi-Experimental Designs for Research. Chicago: Rand-McNally, 1963.

*Castor, Jane, and Kurtz, Edith. A practical social work program for aftercare patients. Hospital and Community Psychiatry, 1966 (January), 25-28.

*Cohen, Leon, Fabrian, Frederick E., and Geiger, Gerald. Patients work in community industry. Hospital and Community Psychiatry, 1969 (March), 90-91.

Criswell, Joan H. Considerations on the permanence of psychiatric rehabilitation. Rehabilitation Literature, 1968 (June), 29(6), 162.

Daniels, David N., and Kuldau, John M. Marginal man, the tether of tradition, and intentional social system therapy. Community Mental Health Journal, 1967, 3, 13-20.

*Daniels, David N., Zelman, Arthur B., and Campbell, Joseph H. Community based task groups in recovery of mental patients. Archives of General Psychiatry, 1967, 16, 215-228.

Davis, Ann E., Dinitz, Simon, and Pasamanick, Benjamin. The prevention of hospitalization in schizophrenia: Five years after an experimental program. American Journal of Orthopsychiatry, 1972 (April), 42(3), 375-388.

*Dincin, Jerry, and Swift, John W. The post hospital schizophrenic patient. The Thresholds, Chicago: VRA Project RD-1058-P.

Dreikurs R. Contemporary Psychotherapies. New York: The Free Press of Glencoe, 1961.

*Fairweather, G. W., Sanders, D. H., Cressler, D. L., and Maynard, H. Community Life for the Mentally Ill: An Alternative to Institutional Care. Chicago: Aldine Press, 1969.

Fiske, D. W., Hunt, H. F., Luborsky, L., Orne, M. T., Parloff, M. B., Reisen, M. F., and Tuma, A. H. Planning of research on effectiveness of psychotherapy. Archives of General Psychiatry, 1970, 22, 22-32.

Gergen, Paul C. Methods in community rehabilitation of ex-mental patients. Paper read at tenth annual research meeting of the Washington State Department of Institutions and the University of Washington School of Medicine, Department of Psychiatry, February, 1970.

Glasscote, Raymond M. (Ed). Rehabilitating the Mentally Ill in the Community. Joint Information Service of the American Psychiatric Association and National Association for Mental Health, 1971.

*Grimberg, M. The surrogate society: A new approach to rehabilitation. Journal of Rehabilitation, 1970 (May-June), 36, 34-35.

Grob, Samuel. Prevocational planning and work conditions for seriously handicapped ex-mental patients: A preliminary report. Mental Hygiene, 1963 (April), 47, 249-260.

Guilford, J. P. Factorial angles to psychology. Psychological Review, 1961, 68, 1-20.

Guilford, J. P. Intelligence: 1965 model. American Psychologist, 1966, 21, 20-26.

*Gumrukcu, Patricia. The Conrad House Report. Conrad House, Inc., San Francisco, California. Final Report, VRA Project RD-908-P, 1966.

Herzberg, F. Work and the Nature of Man. Ohio: World Publishing Co., 1966.

Horizon House: New perspectives in rehabilitation. Hospital and Community Psychiatry, 1966, 290-293.

Hutchison, J. The RST: a service delivery system. Journal of Rehabilitation, 1971, 37(2), 34-36.

Kendel, Denise, and Williams, R. H. Psychiatric Rehabilitation: Some Problems of Research. New York: Atherton Press, 1963.

*Koltuv, M., and Neff, W. S. The comprehensive rehabilitation center: Its role and realm in psychiatric rehabilitation. Community Mental Health Journal, 1968, 4, 251-259.

Kraft, A., Binner, P. R., and Dickey, B. A. The chronic patient. In Williams, R. H., and Ozarin, L. D. (Eds.) Community Mental Health. San Francisco: Jossey-Bass, 1968.

Kroegler, R. R., and Brill, N. Q. Treatment of Psychiatric Outpatients. New York: Appleton-Century-Crofts, 1967.

*LaFave, G., Lawly, L. R., Burke, J. L., Cohen, M. E., Barrington, L., Lee, H. ntensive rehabilitation for chronic patients. Mental Hospitals, 1965, October, 279-281.

*Loether, Herman J. Pathways to mental health: A study of shifts from sick role to well role by residents of halfway house. Portal's House, Inc., Los Angeles, California, Final Report, VRA Project RD-1395-P, 1967.

Longhurst, P. Key factor analysis: A general systems approach to program evaluation. In WICHE. Systems approach to program evaluation in mental health, 1970.

Lorei, T. W. Prediction of community stay and employment for released psychiatric patients. Journal of Consulting Psychology, 1967, 31, 349-357.

Ludwig, Arnold M. Treating the Treatment Failures: The Challenge of Chronic Schizophrenia. New York: Grune and Stratton, 1971.

Meislin, Jack. The need for an intermediary institution. Journal of Hospital and Community Psychiatry, March, 1969, 88-89.

Miller, Dorothy. Alternatives to mental patient rehospitalization. Community Mental Health Journal, 1966, 2, 124-128.

*Neff, W. S. and Koltuv, M. Work and mental disorder: A study of factors involved in the rehabilitation of the vocationally disadvantaged former mental patient. Institute for the Crippled and Disabled, New York, N. Y. Final Report, VRA Project RD-990-P, 1967.

Obermann, C. E. A History of Vocational Rehabilitation in America. Minneapolis: T. S. Denison, 1965.

*Paik, George, Murata, David M., Sanborn, Kenneth O., and Moravec, George J. The remotivation of chronic schizophrenic men patients through the use of "work conditioning" in hospital work areas. Hawaii State Hospital, Kaneohe, Hawaii. Final Report, VRA Project RD-891.

Rogers, Carl R. Client-Centered Therapy: Its Current Practice, Implications, and Theory. Boston: Houghton Mifflin, 1961.

Rutman, Irvin D. Ex-mental patients and halfway houses: Origin and present status. Rehabilitation Record, March-April, 1964, 5, 10-13.

*Rutman, Irvin D. Comprehensive, community-based rehabilitation services for the psychiatrically disabled. Horizon House, Philadelphia, Pennsylvania. Final Report, SRS Project RD-817-P, 1970.

*Schmidt, James R., Nessel, Julius J., and Malamud, Thomas J. An evaluation of rehabilitation services and the role of industry in the community adjustment of psychiatric patients following hospitalization. Fountain House Foundation, New York, New York. Final Report, SRS Project RD-1281-P, 1969.

Schutz, W. C. FIRO: A Three-Dimensional Theory of Interpersonal Behavior. New York: Rinehart, 1958.

Silverstein, Max. Psychiatric Aftercare. Philadelphia: University of Pennsylvania Press, 1968.

*Sturman, John W., Worley, Burt H., and Forster, Jerald R. Vocational evaluation-exploration and resocialization using community job stations and a community live-in teaching facility. Delta Foundation, Everett, Washington. Final Report, SRS Project RD-1940-G, 1969.

Tunakan, Bulent and Schaefer, Irving J. The community boarding house as a transitional residence during aftercare. Current Psychiatric Therapies, 1965, 5, 235-239.

*Tunakan, Bulent, Van Fleet, Charles R., and Johnson, Norma G. Use of community boarding houses as transitional living facilities in vocational rehabilitation of mental hospital patient-clients. Nebraska Psychiatric Institute, Omaha, Nebraska. Final Report, VRA Project RD-1258, 1970.

Ullmann, L. P., and Giovannoni, Jeanne. The development of a self-report measure of the process-reactive continuum. Journal of Nervous and Mental Disorders, 1964, 138, 38-42.

Wahler, H. J. Abandoned people: The plight of chronic mental patients returning to community life. Unpublished mimeo, 1972.

Wahler, H. J. Wahler Self-Description Inventory, Manual. Los Angeles: Western Psychological Services, 1971.

Wahler, H. J. The physical symptoms inventory: Measuring levels of somatic complaining behavior. Journal of Clinical Psychology, 1968, 24, 207-211.

Wahler, H. J. A comparison of the Shipley-Hartford as a power test with the WAIS Verbal scale. Journal of Consulting Psychology, 1962, 26, 105.

Wahler, H. J., Johnson, Robert, and Uhrich, Kenneth. The community mental health expediter project. Washington State Dept. of Social and Health Services, Tacoma, Washington. Final Report, NIMH Project MH-11382, 1972.

Wahler, H. J. and Marks, John. RECOVER: An opportunity program for ex-patients. Hospital and Community Psychiatry, January, 1969, 26-28.

Wallace, J. What units shall we employ? Allport's question revisited. Journal of Consulting Psychology, 1967, 31, 56-64.

Watson, C. G. and Logue, P. E. Interrelationships of several process-reactive measures. Journal of Counseling and Clinical Psychology, 1969, 33, 120-122.

Weinberg, J. L. The contribution of workshop experience in the vocational rehabilitation of first hospitalized schizophrenic patients. Rehabilitation Counseling Bulletin, December, 1964, 58-59.

White, R. W. The experience of efficacy in schizophrenia. Psychiatry: Journal for the Study of Interpersonal Processes, 1965, 28(3), 199-211.

Woodworth, R. S. Dynamics of Behavior. New York: Holt, 1958.

APPENDIX A

Major Life Areas (MLA) Scoring Criteria

The MLA total score reflects adequacy of general social functioning. It is a composite of 5 subscores in the following areas: (1) occupation, (2) marital status, (3) living situation and material possessions, (4) social activities, (5) recreational activities.

Scores may be obtained for each area by using the scoring criteria that follow: scores for each area when combined become the total score. Each of the area scores and the total score also may be converted to T scores based on data from samples of the general population.

T scores are obtained by entering raw scores in the profile sheets. By joining dots made for raw score entries in each area with lines, a profile results which graphically shows the levels of a respondent's scores relative to "normal" standards. (By convention, T scores have a mean of 50 and a standard deviation of 10)

Originally the MLA was a separate questionnaire. To implement obtaining intake information, the five areas were combined with other questions to form a comprehensive, self-administering, Background Information questionnaire.

Questions in each of the five areas are intended to elicit the types of information typically sought in intake interviews. The format requires some "yes-no" type answers, some brief write-ins and some rankings. Questions concern activities over the past year, or over broader spans of past time; they focus on types of activities or conditions and frequencies or durations of these. The intent is to obtain some basic information in each area not to explore it in depth.

Scoring Codes for Each Area

Codes and item numbers are for information obtained from the Background Information questionnaire (Rev. No. 6) (BIQ).

Scoring is facilitated when code values are recorded in the MLA Data Sheet.

1. Occupation: Information from Items (6, 9, 12) 14-20. (Section II in BIQ)

a) Source of Income: Item 6

	Code
Dependent on parents; hospitalized	1
Dependent on relatives or friends	2
Full-time compensation, welfare, VA disability, etc.	3
Earned retirement, partial self-support, Social Security, Unemployment Compensation	4
Self-supporting (full-time homemaker)	5

b) Average Duration: Item 15

1 month or less	1
3 months	2
6 months	3
9 months	4
12 months	5

c) Type Occupation: Item 16

Examples:		
	Has not worked	1
Babysitting, common labor, busboy	Unskilled	2
Fry cook, janitor, attendant, waitress	Semi-skilled	3
All trades, LPN, mechanic	Skilled	4
RN, CPA, teacher, manager, chemist--require 4+ years education &/or experience	Professional, managerial, technical	5

d) Current Status: Items 17, 18, 19 (school items 9, 12)

Note: If part time, reduce duration (not code) by half.

Note: Credit time in school as employment (also half for part time).

No work or less than 1 wk.	1
1 wk. to 1 mo.	2
2 mo. to 5 mo.	3
6 mo. to 11 mo.	4
12 mo. or more	5

Scoring Codes (continued)

2. Marital Status: Information from Items (2) 56, 57, 58, 64, 65, 66. (Section IV in BIQ)

a) Current Status: Item 56

	Code
Never Married	1
Divorced	2
Separated	3
Widowed	4
Married	5

b) Duration: Items (2, 56, 57) 58

i) If not separated or divorced

		M 35 or older F 31 or older	
	M 28-34 F 26-30	Never Married	1
M 18-27 F 18-25	Never Married	Less than 2 yrs.	2
Never Married	Less than 2 yrs.	2+ to 4 yrs.	3
Less than 2 yrs.	2+ to 4 yrs.	4+ to 8 yrs.	4
2 or more yrs.	4+ or more	More than 8 yrs.	5

ii) If separated or divorced (use longest marriage in either case)

Less than 3 mo.	Less than 3 mo.	Less than 3 mo.	1
3 to 6 mo.	3 to 9 mo.	3 mo. to 2 yrs.	2
6 mo. to 1 yr.	9+ mo. to 2 yrs.	2+ yrs to 4 yrs.	3
1+ yr. to 2 yrs.	2+ yrs. to 4 yrs	4+ yrs to 8 yrs.	4
More than 2 yrs.	More than 4 yrs.	More than 8 yrs.	5

c) Engaged-Dating: Items 64, 65

Engaged or going steady	No Dating	1
" " " "	Yes	5
		3

d) Frequency of Dating: Item 66

Note: If Item 64 is yes this does not apply.

None to 1/yr.	1
Every 3 to 6 mo.	2
About 1/mo.	3
2/mo. to 1/wk.	4
2 or more/wk.	5

Scoring Codes (continued)

3. Living Situation and Material Possessions: Information from Items 68-75. (Section V in BIQ)

a) Mobility: Item 68

Note: Move to hospital and back = 1 move.

	Code
More than 3 moves	1
3 moves	2
2 moves	3
1 move	4
No moves	5

b) Type Living Situation: Item 69

Parents, foster home	1
Nursing home, halfway house	2
Relatives, friends	3
Rented room, apt., hotel, boarding	4
Rent, buy house, duplex	5

c) Social Conditions: Items 70, 71

c, Mother, etc.	1
d, f, Other relatives, etc.	2
Self (#70)	3
b, e, With children, etc.	4
a, Spouse, etc.	5

d) Material Needs: Item 72

Note: This item may receive smart response, e.g., million dollars; score such as no need.

3 or more relevant needs	1
1 or 2 relevant needs	3
No needs	5

e) Financial Problems: Items 74, 75

Yes, insufficient income and debts	1
Yes, insufficient income or debts	3
No problems	5

Scoring Codes (continued)

4. Social Activities: Information from Items 77-98. (Section VI-1 in BIQ)

a) Activities with Other People: Items 77-82

Sum numerals encircled (ratings) and divide by the number of ratings, i.e., obtain mean rating; find code for interval in which mean falls.

Mean Rating	Code
0.0 - 1.0	1
1.1 - 2.0	2
2.1 - 3.0	3
3.1 - 4.0	4
4.1 - 5.0	5

b) Organizations or Groups: Items 83-98

Proceed as indicated in a) above.

Mean Rating	Code
0.0 - 1.0	1
1.1 - 2.0	2
2.1 - 3.0	3
3.1 - 4.0	4
4.1 - 5.0	5

5. Recreational Activities: Information from Items 99-112. (Section VI-2 in BIQ)

a) Passive Activities: Items 99-103

Proceed as indicated in a) above.

Mean Rating	Code
0.0 - 1.0	1
1.1 - 2.0	2
2.1 - 3.0	3
3.1 - 4.0	4
4.1 - 5.0	5

b) Active Activities: Items 104-107

Proceed as indicated in a) above.

Mean Rating	Code
0.0 - 1.0	1
1.1 - 2.0	2
2.1 - 3.0	3
3.1 - 4.0	4
4.1 - 5.0	5

Scoring Codes (continued)

c) Productive Activities: Items 108-112

	Mean Rating	Code
	0.0 - 1.0	1
Proceed as indicated in a) above.	1.1 - 2.0	2
	2.1 - 3.0	3
	3.1 - 4.0	4
	4.1 - 5.0	5

MLA DATA SHEET

Name _____ Sex, M__ F__ Age _____ Date _____

1. Occupation

	Source of income	Average duration	Type occupation	Current status
Item No.	6	15	16	17,18,19
Code				

Sum Code	n	M	(T)

2. Marital Status

	Current status	Duration	Engaged-date	Frequency dating
Item No.	56	58	64,65	66
Code				

Sum Code	n	M	(T)

3. Living Situation

	Mobility	Type livng. sit.	Social Conditions	Material needs	Financial problems
Item No.	68	69	70,71	72	74,75
Code					

Sum Code	n	M	(T)

4. Social Activities

	Activities w/ people	Organiz. or groups
Item No.	77-82	83-98
Code		

Sum Code	n	M	(T)

5. Recreation Activities

	Passive activities	Active activities	Productive activities
Item No.	99-103	104-107	108-112
Code			

Sum Code	n	M	(T)

	Sum(Sum Code)	Sum n	M	(T)
TOTAL SCORE:				

PROFILE SHEET for MAJOR LIFE AREAS

Name _____

Date _____

	FEMALES						MALES					
T Score	Occ	Mar	L-S	Soc	L-T	Total Score	Occ	Mar	L-S	Soc	L-T	Total Score
90-			5.0						5.0			
85-			4.7						4.7			5.0
80-			4.5	5.0	5.0	5.0			4.5			4.8
75-			4.3	4.8	4.7	4.7			4.3	5.0	5.0	4.5
70-	5.0	5.0	4.1	4.5	4.4	4.5	5.0	5.0	4.1	4.5	4.5	4.2
65-	4.9	4.9	3.9	4.2	4.1	4.3	4.9	4.8	4.0	4.0	4.0	3.9
60-	4.8	4.7	3.8	3.9	3.9	4.1	4.7	4.5	3.8	3.6	3.6	3.6
55-	4.6	4.4	3.6	3.6	3.7	4.0	4.4	4.2	3.6	3.3	3.3	3.4
50-	4.4	3.8	3.4	3.4	3.5	3.5	4.0	3.9	3.4	3.0	3.0	3.2
45-	4.0	3.1	3.0	2.9	3.1	3.2	3.6	3.3	3.0	2.7	2.7	2.8
40-	3.5	2.2	2.7	2.5	2.8	2.8	2.8	2.3	2.6	2.4	2.4	2.4
35-	2.5	1.8	2.3	1.7	2.4	2.3	2.2	1.7	2.0	2.1	2.1	2.1
30-	1.8	1.4	2.0	1.3	2.0	2.0	1.6	1.4	1.4	1.8	1.8	1.8
25-	1.3	1.0	1.6	1.0	1.7	1.7	1.2	1.2	1.2	1.5	1.5	1.5
20-	1.0		1.2		1.3	1.3	1.0	1.0	1.0	1.2	1.2	1.0
15-			1.0		1.0	1.0				1.0	1.0	

BACKGROUND INFORMATION (Rev. No. 6)

THE PURPOSE OF THIS FORM IS TO OBTAIN SOME INFORMATION ABOUT YOUR BACKGROUND. READ EACH ITEM OR QUESTION CAREFULLY AND GIVE WHAT YOU FEEL IS THE BEST ANSWER. PLEASE DO NOT SKIP ANY QUESTIONS. IF YOU ARE NOT CERTAIN ABOUT AN ANSWER, MAKE THE BEST GUESS YOU CAN.

Name_____ Present Date_____

1. Sex: M___ F___ 2. Birthdate_____

3. Present Address_____

4. Phone_____ 5. Social Security No._____

6. Present source of income or financial support:_____

_____

I. EDUCATION

7. Put a circle around the number of years of school you completed:

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20

8. How old were you when you last attended school?_____

If you have a college degree, what degree(s)?_____

In what major area(s) is your degree?_____

9. Are you attending college now? yes___ no___. If yes, date started_____

10. Vocational Training: Have you had vocational or special training? yes___ no___

11. If yes, what type of training?_____

12. Are you taking vocational training now? yes___ no___.

If yes, date started_____

13. How satisfied or dissatisfied are you with the amount of schooling you have had? Show this by putting a circle around the number below that best tells this.

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neither Satisfied-Dissatisfied	Satisfied	Very Satisfied

II. OCCUPATION

14. When were you first employed? Month_____ Year_____

15. What was the longest time you were employed?

_____years _____months; from_____to_____(approx. dates)

16. What has been your main type of work?_____

17. Are you employed at present? yes____, full time____ part time____; no_____

    If no, when were you employed last?_____

18. If you are a woman, were you in the past or are you a housewife? yes___ no___

    If yes, was (or is) your main occupation that of a homemaker? yes___ no____

    If yes, when did you start being a homemaker? Date_____

    If you stopped being a homemaker, when was that? Date_____

19. Over the past year, how many months were you employed (or a homemaker) all told?_____

20. What was your main kind of work over the past year? _____

Military Service

21. Were you in military service? yes____ no____

22. What branch of service?_____

23. All told, how many years (months) were you in service?_____

    When did you first enter service?_____

    When were you last discharged?_____

24. What was the type of discharge?_____

25. How satisfied or dissatisfied are you with the kind of work you did (or with not working if you were not employed)?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neither Satisfied-Dissatisfied	Satisfied	Very Satisfied

III. FAMILY BACKGROUND

Childhood

26. While you were growing up (to about 18) were your parents living?

    Mother (M) yes____ no____ Father (F) yes____ no____

27. How old were you when (M__ F__) passed on?_____

28. Did you know your real parents? M - yes___ no___; F - yes___ no___

29. Were your parents divorced? yes_____ no_____

30. If yes, how old were you when they divorced?_____

31. If yes, who did you live with?_____

During your childhood (to about 18), what were the following conditions:

32. What was your father's occupation?_____

33. Mother's occupation?_____

34. How many brothers and sisters did you have? Brothers?_____ Sisters?_____

What was your birth order?_____

How do you feel you got along with the following family members when you were a child? (Put a circle around the appropriate number.)

	Poor	Average	Good
35. Father	1	2	3
36. Mother	1	2	3
37. Brother(s)	1	2	3
38. Sister(s)	1	2	3

39. What other relatives were important to you?_____

_____

40. In what locality did you spend most of your childhood?_____

41. Did you have many friends while you were growing up? yes_____ no_____

42. As you got into your teens, did you date girls (or boys)? yes_____ no_____

43. How old were you when you started dating?_____

44. How old were you when you left home and were out on your own?_____

45. All told, how satisfied or dissatisfied were you with your childhood up to about 18?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neither Satisfied-Dissatisfied	Satisfied	Very Satisfied

Current Family Relations

46. Are your parents now living? F - yes_____ no_____ M - yes_____ no_____

47. What is your father's present occupation?_____

48. Mother's present occupation?_____

49. Could your parents help you financially at present? yes____ no____

How do you feel you get along with the following family members at present?

	Poor	Average	Good
50. Father	1	2	3
51. Mother	1	2	3
52. Brother(s)	1	2	3
53. Sister(s)	1	2	3

54. Do you see any of your relatives or family from time to time? yes___ no___

55. If yes, whom do you see most frequently?_____

IV. MARITAL STATUS

56. Please check your present marital status: Never Married____ Divorced____

Separated____ Widowed____ Married____

57. All told, how many marriages have you had?_____

58. How long were you married each time (including your present marriage)?

First marriage: from_____to_____

Second " : from_____to_____

Third " : from_____to_____

Fourth " : from_____to_____

59. How many children do you have?_____ How many live with you now?_____

60. How old is your youngest child?_____ How old is the oldest?_____

61. If married, does your husband or wife work? yes____ no____

62. What is your husband's or wife's present occupation?_____

63. What is his or her approximate monthly salary?_____

64. If you are single (not married at present for any reason), are you engaged or going steady with someone? yes____ no____

65. If not engaged or going steady, do you date from time to time? yes___ no___

66. About how often do you have dates? Check one: None to about once a year___; about every 3 to 6 months___; about once a month___; twice a month to once a week___; two or more times a week___.

67. How satisfied or dissatisfied are you with your present marital situation?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neither Satisfied-Dissatisfied	Satisfied	Very Satisfied

V. LIVING SITUATION AND MATERIAL POSSESSIONS

68. How many times did you move during the past year: More than 3 moves___;

3 moves___; 2 moves___; 1 move___; no moves___.

69. During the past year, what kind of living quarters did you have? (If you moved several times, what kind of place did you live in during most of the past year?)

Check one: Nursing home___; halfway house___; foster home___; living with parents___; with other relative___; with friend___; rented room___; hotel___; rooming or boarding house___; apartment___; rented house or duplex___; house which I (we) own or are buying___; other:_____

_____

70. During the past year, did you live alone most of the time? yes____ no___

71. If no, which of the following did you live with most of the time over the past year? (Check appropriate space):

a) Spouse (and own family)___
b) Only with children (or child): were children over 18___ under 18___ both___
c) Mother (or step-M)___ Father (or step-F)___; other patients (if in hosp.)___
d) Other relatives___; their relationship_____
e) Friend(s) or roommate(s)___
f) In-laws___; their relationship_____

72. What household or personal things do you badly need? Please list below:

_____

_____

73. Do you intend to remain in your present living situation? yes____ no____

Financial Problems

74. Have you had problems with debts during the past year? yes____ no____

75. If yes, what were the main causes of these problems?_____

_____

76. In general, how satisfied or dissatisfied are you with your living situation (or situations) over the past year?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neither Satisfied-Dissatisfied	Satisfied	Very Satisfied

VI. LEISURE TIME ACTIVITIES

The purpose of this section is to obtain some information about the kinds of things you do when not working or taking care of daily living needs.

1. SOCIAL ACTIVITIES

a) Activities with other People

What do you do to be with other people?
About how often do you do these things?

Please show about how often you do the following kinds of social things, encircling the number after each item that best shows this. (If not sure, give your best guess). Think of your activities over the past year.

1	2	3	4	5
Never to Almost Never	Very Seldom to Once in a while	Occasionally to Fairly Often	Often	Very Often (More than once a week)

77. Visit or talk on the phone with relatives, friends, acquaintances 1 2 3 4 5

78. Give or go to parties, dinners, picnics 1 2 3 4 5

79. Participate in sports or any kind of games with others 1 2 3 4 5

80. Go places with friends or relatives; for example, shows, dances, outings, trips 1 2 3 4 5

81. Attend meetings or planned activities; for example, church, clubs or social organizations 1 2 3 4 5

82. Please list any other kinds of social things you do that are not covered by the above. (Be sure to show about how often you do them.)

_____ 1 2 3 4 5

_____ 1 2 3 4 5

_____ 1 2 3 4 5

b) Organizations or Groups

What kinds of organizations or groups do you belong to?
How actively do you participate in those you belong to?

Following is a list of 16 different kinds of organizations or groups. Please show whether or not you belong to the kind of organization indicated and how actively you participate. Do this by encircling the appropriate number after each item.

The scale below tells what each number means.

1	2	3	4	5
Do not Belong	Belong - Attend very few meetings	Attend some meetings and go to some activities	Attend regularly; participate in most activities	Attend and participate regularly; active in organization leadership

83.	Church or religious organizations	1 2 3 4 5
84.	Sports club, organization or league (Gun, motorcycle, bowling, fishing, etc.)	1 2 3 4 5
85.	Fraternal or civic organizations, lodges, leagues or auxiliaries (Elks, Moose, Lions, Rotary, etc.)	1 2 3 4 5
86.	Military organizations (NCO Club, Officers Club, American Legion, VFW, etc.)	1 2 3 4 5
87.	School organizations (PTA, nursery school, etc.)	1 2 3 4 5
88.	National or ethnic organizations (Sons of Italy, German Club, Indian gathering, British American Club, etc.)	1 2 3 4 5
89.	Health organizations (Health Spa, TOPS Club, etc.)	1 2 3 4 5
90.	Special interest organizations (Garden club, dance club, Canasta club, Acquarian Foundation, etc.)	1 2 3 4 5
91.	Labor organizations, unions	1 2 3 4 5
92.	Social action groups, councils (Welfare Rights Action Council, Mothers March, Mentally Retarded March, Citizens for Kidney Patients, etc.)	1 2 3 4 5
93.	Performing groups (Barbershop Chorus, church choir, Community Playhouse, etc.)	1 2 3 4 5
94.	Learning, self-development groups (reading and discussion group, etc.)	1 2 3 4 5
95.	Mutual help groups (Neurotics Anonymous, Alcoholics Anonymous, etc)	1 2 3 4 5
96.	Professional organizations (State Nurses' Assn., American Dietetic Assn., National Assn., of Social Workers, National Ed. Assn., etc.)	1 2 3 4 5
97.	Business organizations (Grange, Commerce Club, JayCee, etc.)	1 2 3 4 5
98.	Multiple purpose organizations (YMCA, YWCA, 4-H, etc.)	1 2 3 4 5

2. RECREATIONAL ACTIVITIES

What are the main kinds of things you do for recreation, for entertainment or just to pass time? About how often do you do these things?

a) Passive Activities

What kinds of things do you do for recreation that do not require much action or effort? Think of things you usually do by yourself--or without being involved with someone else.

Please show how often you do the following things by encircling the appropriate number after each item. The scale below shows what the numbers mean.

1	2	3	4	5
Never or Almost Never	Very Seldom to Once in a While	Occasionally to Fairly Often	Often	Very Often (more than once a week)

99. Watch TV or listen to radio 1 2 3 4 5

100. Read novels, magazines, comics, etc. (entertainment reading) 1 2 3 4 5

101. Go to movies, plays or other performances 1 2 3 4 5

102. Do nothing; sit, relax, nap 1 2 3 4 5

103. List other things you do for entertainment or to pass time that do not require much effort:

_____ 1 2 3 4 5

_____ 1 2 3 4 5

_____ 1 2 3 4 5

b) Active Activities

What kinds of things do you do for recreation that are active and do require effort? Show about how often you do the following kinds of things:

104. Engage in sports (any type of team sports, exercise, job, swim, fish, hunt, ride horses) 1 2 3 4 5

105. Take trips, camp, hike 1 2 3 4 5

106. Play active games requiring skill (bowl, pool, golf, tennis) 1 2 3 4 5

107. List other active things you do for recreation:

_____ 1 2 3 4 5

_____ 1 2 3 4 5

_____ 1 2 3 4 5

c) Productive Activities

What kinds of things do you do to create or make things or learn something? About how often do you do these things?

1	2	3	4	5
Never or Almost Never	Very Seldom to Once in a While	Occasionally to Fairly Often	Often	Very Often (more than once a week)

108. Make or create things (sew, cook special dishes, do woodwork, paint, write, repair things) 1 2 3 4 5

109. Maintain or develop skills (practice or play a musical instrument, work to improve skill in games or sports--bridge, chess, golf) 1 2 3 4 5

110. Take courses, study, attend workshops or lectures 1 2 3 4 5

111. Volunteer work (school, hospital, church, political) 1 2 3 4 5

112. List other productive activities not included above:

_____ 1 2 3 4 5

_____ 1 2 3 4 5

_____ 1 2 3 4 5

113. In general, how satisfied or dissatisfied are you with your social and leisure time activities?

1	2	3	4	5
Very Dissatisfied	Dissatisfied	Neither Satisfied-Dissatisfied	Satisfied	Very Satisfied

VII. MEDICAL HISTORY

114. Have you had any serious physical illnesses or injuries any time in your life up to the present? yes___ no___

If yes, list the type of injury or illness in order of occurrence:

Type of injury or illness

1)_____

year_____; hospitalized? yes___ no___; If yes, how long?_____

Were there any after-effects? yes___ no___; If yes, describe:

_____

2)_____

year_____; hospitalized? yes___ no___; If yes, how long?_____

Were there any after-effects? yes___ no___; If yes, describe:

_____

3)_____

year_____; hospitalized? yes___ no___; If yes, how long?_____

Were there any after-effects? yes___ no___; If yes, describe:

_____

115. Did you ever have any head injuries or brain diseases (e.g., encephalitis, stroke, etc.)? yes___ no___ If yes, describe the type of brain injury or illness:_____

year_____; hospitalized? yes___ no___; If yes, how long?_____

Were you unconscious? yes___ no___ If yes, how long?_____

116. Have you had trouble with any of the following over the past year?

	None	Some	Alot
Dizziness	1	2	3
Headaches	1	2	3
Fainting	1	2	3
Trouble with vision	1	2	3
Seizures	1	2	3
Paralysis or numbness	1	2	3
Other problems_____	1	2	3

117. How poor or good is your present physical health?

1	2	3	4	5
Very Poor	Poor	Adequate	Good	Very Good

VIII. PSYCHIATRIC HOSPITALIZATIONS AND TREATMENT

118. Have you received treatment in a mental hospital? yes___ no___

119. If yes, how many times, all told_____

120. How old were you when you first went to a mental hospital?_____

121. What do you feel were the main reasons for your going to a mental hospital?

_____

_____

_____

122. When were you in a mental hospital the last time? From_____to_____

123. Where?_____

Medication

124. Are you taking medication at present? yes___ no___

Name of Medication	Dosage	Date Began

125. Name & Address of doctor prescribing medication:_____

_____

126. Are you getting prescriptions from this doctor at present? yes___ no___

127. How do you feel about your medication?

Is it helping you? yes___ no___

Are you getting the right amount? yes___ no___

If no, explain:_____

IX. SOCIAL PROBLEMS

1) Problems with Alcohol

128. Has alcohol been a problem? yes___ no___

129. If yes, how long has it been a problem?_____

130. How long have you been dry?_____

2) Problems with Drugs

131. Have drugs ever been a problem? yes___ no___

132. If so, describe (type drug(s), how used and dates):_____

_____

_____

133. Are you having difficulties with drugs at present? yes___ no___

134. If yes, what kind of difficulty?_____

_____

3) Social Offenses

135. Have you ever had difficulties with the law or courts, not counting minor traffic citations? yes___ no___

136. If yes, describe: a) the type of offense(s) b) date(s) and c) outcome(s)

a) Type of Offense b) Date

_____ _____

c) Outcome_____

a)_____ b)_____

c) Outcome_____

a)_____ b)_____

c) Outcome_____

a)_____ b)_____

c) Outcome_____

137. Are you on probation or parole at the present time? yes___ no___

138. If so, for what offense?_____

139. Terms of probation or parole: a) began_____ b) ends_____

c) special conditions:_____

140. Name of probation or parole officer:_____

Address:_____ Phone:_____

X. PERSONAL APPRAISAL

141. What do you see as your main problems at the present time?

Personal Assets and Liabilities

142. What do you feel are your five best qualities as a person?

143. What do you feel are your five worst qualities as a person?

Need for Program

144. What do you want to accomplish by being in the RECOVER Program?

APPENDIX B

Correlational Matrix: Major Background Measures

			MLA					
	EI3	P-R	OCC	MS	LS	SA	LT	TS
IHT3[a]	-.44*	.29*	-.26*	-.05	.05	-.25*	-.07	-.12
EI3		-.29*	.36*	.27*	.10	.17	-.01	.29*
P-R			-.29*	-.26*	-.04	-.58*	-.41*	-.57*
OCC				.31*	.20*	.19*	-.04	.47*
MS					.30*	.01	-.02	.44*
LS						-.16	-.14	.27*
SA							.51*	.64*
LT								.56*

[a] IHT3 = 3-year pre In-Hospital-Time; EI3 = 3-year pre Employment Index; P-R = Process-Reactive (high score = process); MLA = Major Life Area scores: OCC = Occupation; MS = Marital Situation; LS = Living Situation; SA = Social Activities; LT = Leisure Time activities; TS = Total Score. *Significant at .05 level or less; all correlations based on combined male and female Graduate and Terminate groups; Ns = 79 or 80.

APPENDIX C-1

Mean Self-Description Scores, Estimated Verbal IQ (S-H)
and Process-Reactive Scores (P-R)

		REJECTED				ACCEPTED							
		Too Disturbed		Character Disorder		Graduates		Terminates+30		Terminates-30		Normals	
	N	27	20	19	10	19	30	13	17	11	23	42	61
		M	F	M	F	M	F	M	F	M	F	M	F
I&P	M_2	43	36	33	27	37	36	35	41	38	38	44	53
	σ^2	196	161	228	99	162	114	116	291	376	136	146	87
SDI uf	M_2	3.0	3.2	3.1	2.6	3.2	3.9	2.6	4.2	3.5	3.6	2.5	2.4
	σ^2	2.4	3.0	2.7	5.3	4.2	3.8	1.5	3.1	2.1	2.1	.8	.8
SDI fa	M	4.8	5.2	4.8	3.7	4.1	4.0	4.0	4.2	4.1	4.2	5.2	5.3
	σ^2	1.7	1.1	1.8	1.3	2.8	2.8	2.0	3.2	1.0	1.3	.5	1.2
PSI	M_2	.8	1.0	1.0	.4	.5	1.0	.7	1.3	.9	1.1	.7	.8
	σ^2	.3	.3	.7	.1	.2	.6	.2	1.0	.2	.5	.3	.2
S-H	M_2	104	94	104	91	98	105	98	106	103	104		
	σ^2	187	75	57	66	174	72	164	109	144	74		
P-R	M_2	27	27	24	25	26	23	29	24	27	24		
	σ^2	25	59	79	43	40	37	41	37	30	30		

APPENDIX C-2

Mean MMPI, Kuder and FIRO-B Scores

MMPI (k weighted T scores)

		N	K	Hs	D	Hy	Pd	Pa	Pt	Sc	Ma	Si	Sd	De	Un
Graduates	M	17	54	58	67	59	70	57	68	72	63	56	27[a]	62[b]	38[b]
	F	26	51	56	64	61	69	67	68	68	64	58	24	55	48
Terminates+30	M	8	48	54	71	58	74	67	80	79	60	64	20	57	57
	F	13	49	57	69	61	78	67	72	76	62	66	20	50	60

KUDER (percentile ranks)

			Out-door	Mech.	Comp.	Sci-ence	Pers-uas.	Art.	Lit.	Music	Soc. Sci.	Cleric.
Graduates	M	15	47	22	52	49	48	51	48	49	68	49
	F	20	61	57	41	53	50	54	50	50	71	41
Terminates+30	M	7	44	27	36	43	34	70	70	51	83	30
	F	10	34	39	40	49	37	63	53	66	65	38

FIRO-B (percentile ranks)

			EXPRESSED			WANTED		
			Inclusion	Control	Affection	Inclusion	Control	Affection
Graduates	M	17	33	44	49	33	42	38
	F	23	45	30	49	46	46	55
Terminates+30	M	8	16	33	36	41	52	53
	F	12	44	32	56	69	68	63

[a]Expressed in raw scores; maximum score = 39.
[b]Average percentage of "true" responses; each scale contains 60 items.

APPENDIX D

Summaries of Analysis of Variance
for In-Hospital-Time

Males

Sources	df	MS	F	p
Between Groups (G)	4	570.6	.77	ns
Error (between)	112	741.5		
Pre-Post (P)	1	6,666.3	18.63	<.001
G x P	4	718.2	2.01	.05<P<.10
Error (within)	112	357.8		

Females

Sources	df	MS	F	p
Between Groups (G)	4	2,605.5	3.51	<.01
Error (between)	132	742.8		
Pre-Post (P)	1	1,120.1	3.61	<.01
G x P	4	156.6	.51	ns
Error (within)	132	309.9		

APPENDIX E

Summaries of Analysis of Variance
for Time Employed

Males

Sources	df	MS	F	p
Between Groups (G)	1	6,564.5	4.39	<.05
Error (between)	25	1,495.9		
Pre-Post (P)	1	816.6	.63	ns
G x P	1	6,165.3	4.74	<.05
Error (within)	25	1,301.4		

Females

Sources	df	MS	F	p
Between Groups (G)	1	4,455.0	2.03	ns
Error (between)	35	2,195.5		
Pre-Post (P)	1	1,743.3	1.47	ns
G x P	1	921.4	.78	ns
Error (within)	35	1,184.6		

APPENDIX F

Summary of Analysis of Variance
for Social Adequacy (Major Life Areas Total Scores)

Males

Sources	df	MS	F	p
Between Groups (G)	1	.1	---	ns
Error (between)	16	55.1		
Pre-Post (P)	1	812.2	18.0	<.001
G x P	1	2.9	---	ns
Error (within)	16	45.2		

Females

Sources	df	MS	F	p
Between Groups (g)	1	1.4	---	ns
Error (between)	33	91.9		
Pre-Post (P)	1	1,260.1	30.8	<.001
G x P	1	39.2	1.0	
Error (within)	33	40.9		

APPENDIX G

Pre- and Post-Mean Scores
for SDI, PSI and I&P

		Graduates				Terminates+30			
		M		F		M		F	
		Pre	Post	Pre	Post	Pre	Post	Pre	Post
SDI fa	M	4.1	4.7	4.0	4.3	4.0	4.3	4.2	4.9
	N	18	11	30	18	12	4	17	3
	σ^2	2.8	2.3	2.8	2.5	2.0	.7	3.3	3.7
SDI uf	M	3.2	3.1	3.9	3.1	2.6	2.7	4.2	2.7
	N	18	11	30	18	12	4	17	3
	σ^2	4.2	4.0	3.8	2.6	1.7	1.4	3.1	4.0
PSI	M	.5	.5	1.0	1.5	.7	.8	1.3	.9
	N	18	11	29	17	12	4	17	3
	σ^2	.2	.2	.6	2.8	.2	.3	1.0	.3
I&P	M	37	41	36	33	35	33	41	32
	N	17	10	29	17	12	4	15	3
	σ^2	161	90	114	130	117	42	292	296

ERIC Clearinghouse
JUL 1 0 1973
on Adult Education